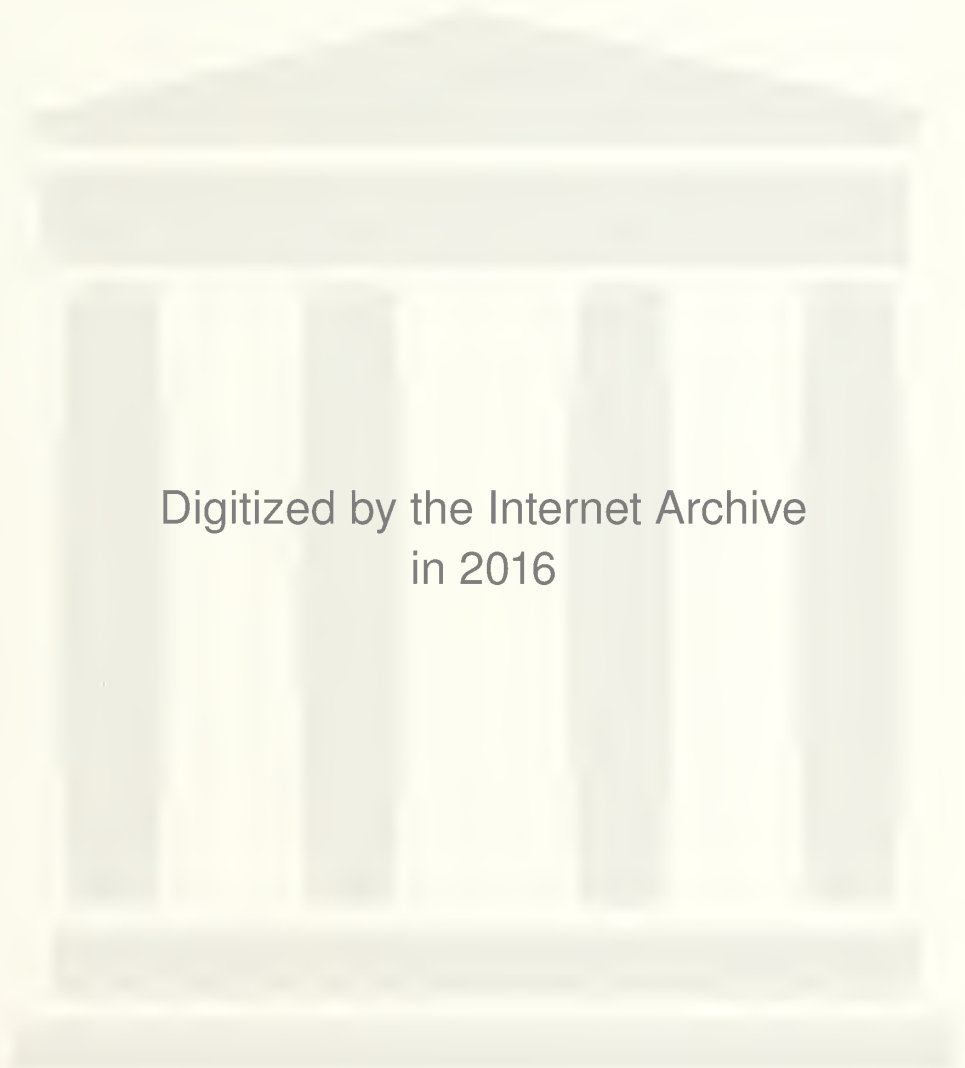
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IMJ

Illinois Medical Journal

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

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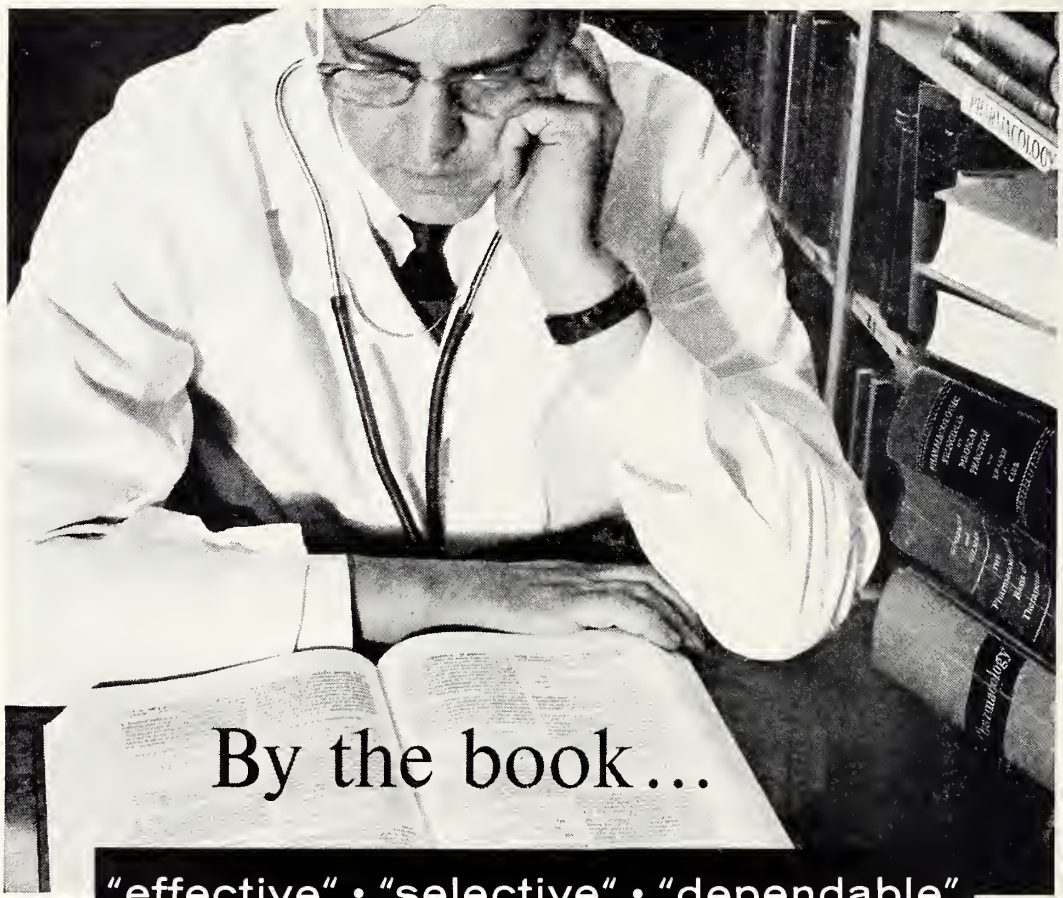
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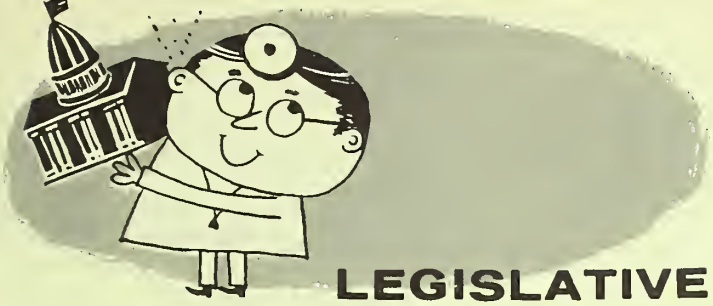
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LEGISLATIVE LISTENING POST

January, 1964

KING-ANDERSON HEARINGS RESUMED

Eldercare was in the spotlight as the Second Session of the 88th Congress opened January 7. Hearings by the House Ways and Means Committee on HR-3920, interrupted by the death of President Kennedy some weeks ago, are scheduled to resume January 20.

The Committee will receive testimony from only those witnesses whose appearances were postponed as a result of the President's death. Representatives of organizations yet to testify include: Blue Cross-Blue Shield; American Farm Bureau; U. S. Chamber of Commerce; and Illinois Manufacturers Association, all of whom are expected to oppose HR-3920. George Meany of the AFL-CIO; the Farmers Union; and the Americans for Democratic Action (ADA) are among the supporters yet to testify.

NEW ELDERCARE LEGISLATION INTRODUCED

Senator Javits, and five other liberal Republicans, have introduced a compromise proposal involving voluntary health insurance as a lamb lying down with the Social Security lion. The scheme embraces hospitalization and other benefits of HR-3920 under Social Security, plus coverage for those not on Social Security, financed out of general revenues. Private insurance would be asked to team up for other benefits in conjunction with the program. Senator Margaret Chase Smith, Maine, Vice Presidential aspirant, is a new member of this liberal group. Other senators in the group are: Case of New Jersey, Cooper of Kentucky, Keating of New York, and Kuchel of California.

CALL TO ARMS

On January 6, Senate Democratic leader Mike Mansfield said, "The President wants Health Care for the Aged (health care not medicare, Mansfield emphasized) given high priority." A tremendous push by the supporters of HR-3920 to move the bill out of the House Ways and Means Committee for a floor vote following the January 20 hearings, is fully anticipated. Physicians and their allies cannot afford to be found resting on their oars when this occurs.

AMA President, Edward R. Annis, M. D., recently called for an all-out effort to defeat the King-Anderson bill. "It is necessary to have a deluge of expression from the grass roots of this nation, reaching Washington in such volume it cannot be ignored," he said. "Remember, every letter, every word of opposition from a non-doctor, has tremendous impact."

PUBLIC AFFAIRS CONFERENCE

The Illinois State Medical Society shall again sponsor its Public Affairs visit by physicians and their wives to Washington, D.C. The dates are February 4-5-6. A special ISMS Program on February 4 will include breakfast and luncheon meetings on Public Affairs topics and a reception and dinner for the Illinois Senators and Congressional delegation in the evening. Individual visits with members of Congress will be interspersed over the 3-day period. February 5 and 6 will be devoted to attendance at the Annual U. S. Chamber of Commerce Public Affairs Conference, featuring top-notch public officials. All physicians and their wives are urged to join the delegation. This is a wonderful opportunity to mingle with other people of this nation having an interest in public affairs, as well as meeting your own elected officials in the nation's capital.

Full details, including reservation forms, may be secured from the ISMS Regional Office, 520 South 6th Street, Springfield. Telephone: Area Code 217 528-5609.

FIRST SPECIAL SESSION 73RD GENERAL ASSEMBLY

A special session of the General Assembly was convened by Governor Kerner in Springfield January 6 to resolve the difficulties created by the at-large election of all 177 House members this year. Much heat has been generated over the issue with a great deal of light yet to be forthcoming as to what can be done to alleviate the confusion. Details of the various proposals have been widely reported in the public news media. Included in the Governor's call are three additional items not widely reported:

1. Provide for state aid for schools which closed on the national day of mourning, November 25.
2. Provide for compensation for associate judges assigned to serve outside their home counties.
3. Designate the Board of Higher Education to administer the Federal Higher Education Facilities Act of 1963.

The General Assembly is expected to debate the proposals the week of January 13. The deadline for candidate filing of petitions is January 27.

KERR-MILLS PROGRAM BROADENED

Drugs and nursing home care following hospitalization will now be paid for under Illinois Kerr-Mills. The broadened benefits for qualified AMIA recipients include the cost of drugs prescribed during the 30 days following hospitalization and up to 90 days nursing home care following release from the hospital.

Physicians' services and drugs will also be paid for during the 90 days nursing home care period. The additional benefits go into effect February 1, according to the Department of Public Aid.

Eligibility requirements were relaxed by the 1963 legislature. The straight 10% income deductible was eliminated and is now graduated upward from 0% on an annual income of $1200 to a maximum of 10% at $1800.

Broadened benefits were brought about as a result of frequent meetings of the State Society's Legislative Committee and the Department of Public Aid's staff. Further broadening of benefits and lessening of eligibility requirements are anticipated in the future in response to the needs.

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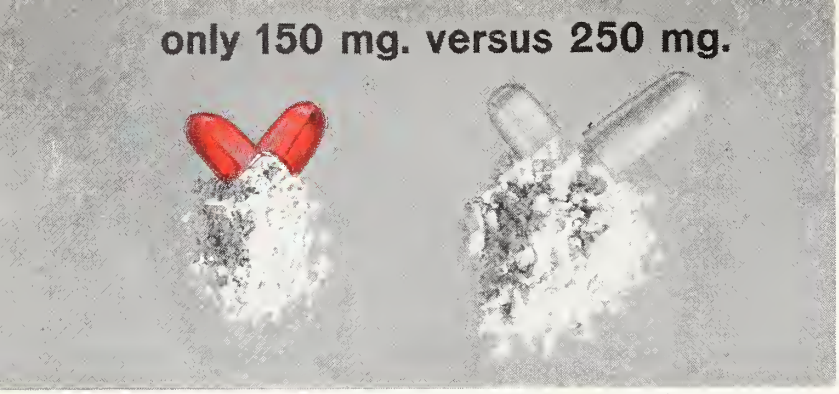
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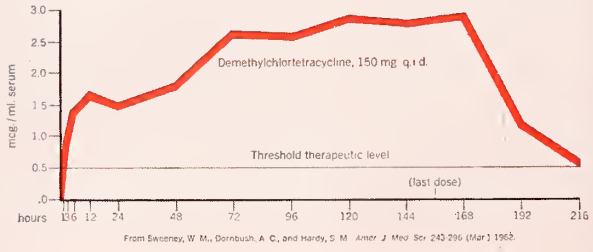
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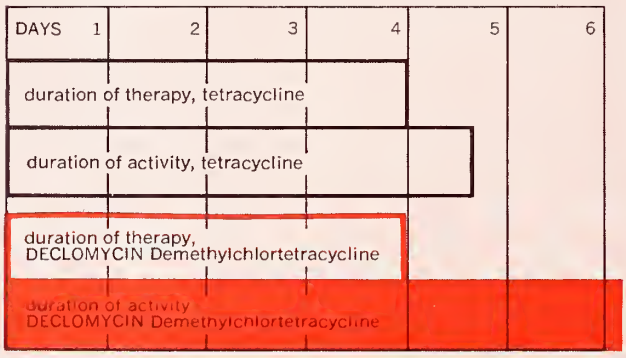


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AS I SEE IT FROM '360'

By Robert L. Richards
Executive Administrator

Auxiliary, Society Work For Common Goals

In the home it is important to know who is responsible for payment of bills, the social life and activities, the care of the children—the maintenance of the bricks and mortar, so to speak. In administration it is particularly important that the left hand know what the right hand is doing. In the office of the State Medical Society we have this same corollary because we not only have ten thousand physician members but we also have three thousand Auxiliary members who are serving the Society.

In recent years the Auxiliary has proven again and again its ability to activate difficult programs, and to correlate the activities with committees constituted by the State Society. A recent move by the Board of Trustees of the State Society to have the Auxiliary's president name liaison representatives to key committees has already stimulated Auxiliary leaders. During the past six months well planned regional meetings of the Auxiliary have been conducted under the guidance of their officers. Modest assistance by the staff and officers of state and county medical societies has been extended, but by and large the members of the Auxiliary have become enthusiastic because of the leadership demonstrated by Mrs. Matthew E. Uznanski, president, and her excellent Board of Directors and committee chairmen.

It has been pleasant and rewarding to the officers of the State Society to see and hear from Auxiliary membership about their interest in rural health, public affairs, public relations, health career recruitment, operation hometown, and other activities so intertwined with the administration of the Society. This interest is supported by an increase in the number of inquiries and requests we receive from Auxiliary members for materials.

As I see it, as this interest continues to grow, we will find the Auxiliary performing more and more satisfactorily, as well as more happily for the Society. The ladies have important functions to carry out, and I believe they will do them well.

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National Diet Heart Study

Diet is considered by many to be one of the important factors in the causation of arteriosclerotic heart disease and the premature occurrence of coronary disease. As a result of evidence collected to date, the United States Public Health Service set up a special committee on diet and heart disease to evaluate the problem.

The committee considered the problem for over two years and organized the National Diet-Heart Study as a means of determining the effects of a special diet on a group of volunteers. A controlled study was deemed essential and a great deal of preparatory work had to be accomplished before the program started. The study is now on its way and expected to last four to five years, and is being carried out in six centers in this country (Chicago is one of these). Applicants were chosen between the ages of 45-54, married, living at home with their wives, and take the majority of their meals at home. The names were procured with the assistance of the United States Bureau of Census and the men were invited to partake in the program. The diet of the participants is lowered in the amount of cholesterol and in the amount of saturated fatty acids.

Following a thorough physical examination, 250 men were selected in each area. Many, of course, were excluded because they failed their physical examination, ate too many meals away from home, or showed no interest. The participants and their wives were interviewed and advised regarding the special diets formulated by the committee. The foods commonly used in the average home that have high cholesterol and fat contents have been altered and specially prepared. Distribution is made to the family upon order by the wife of the participant. The entire family eat the same basic diet as the participant but if desired, the wife and children can eat other foods off the "verboten" list.

The present investigation now in progress is a pilot study. If the results warrant confirmation and further observation, more men will be included. At present, no additional participants are being solicited and future progress reports will be made at appropriate times.

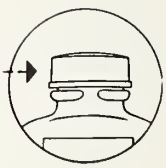
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volume 125, number 1 january, 1964

Water Composition and Cardiovascular Health

Because of the vital role wholesome water plays in public health, The Educational and Scientific Foundation of the Illinois State Medical Society accepted the request from the Water Conditioning Research Council to pose, to a panel of experts, the question: Is there a relationship between dissolved inorganic constituents of drinking water and cardiovascular disease?

They invited six scientists, oriented to various aspects of the problem, to study the subject and prepare a statement of group opinion. The panel was asked to consider also whether or not research in this field seemed to be indicated, and if so, to suggest the direction it might take.

The panel consists of the following members:

John H. Dingle, M.D., Sc.D.
Western Reserve University
Cleveland, Ohio

Oglesby Paul, M.D.
Northwestern University
Chicago, Illinois

W. H. Sebrell, Jr., M.D.
Columbia University
New York, N.Y.

William H. Strain, Ph.D.
University of Rochester
Rochester, New York

Abel Wolman, Dr. Eng.
The Johns Hopkins University
Baltimore, Maryland

James R. Wilson, M.D.
Coordinator for the Educational &
Scientific Foundation of the
Illinois State Medical Society
Chicago, Illinois

Introduction

Medical men are aware of the danger to the public health, of drinking water which contains disease producing bacteria or viruses, or recognized toxic substances, or the pollutants resulting from industrial and population growth. But it is not with any of these that we have been asked to concern ourselves. Rather the problem to be considered is whether dissolved inorganic ingredients in drinking water exert a protective or a deleterious effect on cardiovascular disease in man.

Attempts to relate environmental factors to causes of death among population groups is a popular but hazardous research technique. Results must be critically examined.

Composition of River Water in Japan and Deaths from Apoplexy

Since 1942 Jun Kobayashi has studied the water from some 600 rivers in Japan from the standpoint of agriculture and irrigation. In 1957,[1] he called attention to the high content of sulfate in river water in areas showing the highest incidence of "apoplexy", as shown by the death rate from that condition in 1950, published by the Analysis Section, Statistical Department, Welfare Minister's Office, Japan. This report stimulated interest elsewhere in the possibility of a relationship between dissolved inorganic constituents in drinking water, and cardiovascular health or disease.

Municipal Water Supplies and Cardiovascular Deaths in the United States

In 1960, H. A. Schroeder,[2] West Brattleboro, Vermont, suggested that " . . . some quality of water might influence mortality from one or several cardiovascular diseases." With this in mind he studied death rates of the United States in relation to known constituents and characteristics of drinking water.

Schroeder studied (a) weighted average hardness of finished water by state and age-adjusted average death rates also by state; (b) the same quality of water and age-adjusted death rates by state for white males aged 45 to 64 years; (c) 20 constituents of drinking water and age-adjusted death rates for white males, aged 45 to 64 years, from all causes and from arteriosclerotic heart disease, in each of 163 large metropolitan areas in the United States.

On the basis of his calculations, Schroeder suggested a possible relationship between cardiovascular disease and some constituent or characteristic of drinking water. His calculations tended to exclude a considerable number of the constituents of drinking water including iron, manganese, carbonate and nitrate, sodium and potassium. He did not find the sulfate-bicarbonate ratio to be significantly correlated. He found no correlation with the number of different treatments given water, which included softening with lime or soda ash, chlorination, carbonation, sedimentation, filtration, coagulation with ferric sulfate or alum, aeration, adjustment of pH value, and the addition of copper sulfate or polyphosphate. Nor did he find color or turbidity of water associated with variations in mortality.

However, Schroeder reported significant negative correlations with contents of magnesium, calcium, sulfate, fluoride, total dissolved solids, and specific conductance. He states, "The meaning of this apparent influence on cardiovascular death rates is unclear, but a modicum of speculation is in order. . . ."

Schroeder continues, "For several years reasons for the wide geographical variation in death rates from cardiovascular diseases in this country have been discussed speculatively, according to prevailing fashions of etiological thinking. This report does not solve the problem, nor does it suggest definite causes. . . ."

On the basis of Schroeder's calculations, the average annual age-adjusted total death rates from cardiovascular disease tend to be less than the national average in states where drinking water contains a larger amount of dissolved inorganic material than the national average. However, there are exceptions, and these exceptions require study and an explanation, for when exceptions remain unexplained they constitute grounds for doubt. For example, the highest death rate and one of the lowest death rates occur in states which have the two lowest figures for dissolved inorganic material in their water supplies (18 and 17 parts per million).

In December, 1960, Schroeder extended his

observations in a paper published in the *Journal of Chronic Diseases*.[3] In this paper he gave consideration to other chronic illnesses in addition to those involving the cardiovascular system.

Water-Supplies and Cardiovascular Mortality in Parts of England and Wales

J. N. Morris, M. D. Crawford and J. A. Heady[4] of the London Hospital Medical College conducted a study using available official statistics from county boroughs of England and Wales. The authors stated, "Correlations were calculated between (a) death rates from thirty-eight causes and groups of causes of death in 170 sex-age brackets . . ., and (b) indices of average hardness of the local water as finished and delivered into supply in the 83 county boroughs."

On the basis of their statistical studies, the authors suggested, "The softer the water-supply in the county boroughs of England and Wales the higher the local death-rate from cardiovascular disease tends to be. What this means is not at present clear, and further investigation is indicated."

They wrote, "The main problem in this kind of 'ecological' study is to determine whether the correlations found between water hardness and cardiovascular disease are likely to represent cause and effect, or whether they merely reflect other factors with which both the water and the mortality are associated."

In this study, as in Schroeder's, exceptions are noted and forthrightly reported. Morris, Crawford and Heady state, ". . . Birmingham, with very soft water, has low mortality similar to the neighboring Midland county boroughs with their hard water. This observation may well be crucial, though difficult to interpret in view of the traffic and exchange there is among people, food, and drink across local boundaries within a region." Greenberg, B. G.,[5] quotes J. A. Heady to the effect that similar negative correlations have been found in Scotland.

In a letter to *Lancet* of May 27, 1961, Schroeder[6] called pointed attention to certain similarities and differences in the results of statistical studies of inorganic constituents of water in relation to cardiovascular diseases as reported from Japan, United States and Britain.

He pointed out that in Japan there are regional differences in mortality from cardiovascular disease which ". . . appear to correlate reasonably well with the sulphate-bicarbonate ratios of 'raw' (untreated) river waters . . . but not with hardness of water. The river waters are soft and are low in calcium and magnesium. . . . If the same factor influencing death-rates in the United States and England is operating in Japan, it is not necessarily associated with hardness of water. . . ."

Schroeder compared other results obtained in the three countries, Japan, England, and United States. Among them, he pointed out that "In the United States, both calcium and magnesium, the principal cations making up hardness of water, correlate well with male death-rates from coronary heart-disease in 163 cities and with each other ($r = 0.823$, $P<0.001$). In England magnesium showed a low correlation, while neither cation appeared to be significant in Japan. The coefficient of correlation with sulphate was significant in the United States and less so in Japan."

Other inconsistences in observations and statistical considerations are mentioned. Schroeder writes, "One must always tread warily through mazes of statistics, for pitfalls are many." One must emphasize, he indicates, that this supposed water factor "whatever it is, is only an influence, probably on the course or severity of these disorders, and by no means can be considered as causal at the present time. . . . Whether or not there is superimposed upon it a man-made synergistic influence, a product of civilisation (such as water pipes), remains to be seen."

Rabbit Studies

An experimental approach was made to a study of certain aspects of this problem by J. B. and M. Neal,[7] of Jacksonville, Florida, using rabbits. The number of animals used was small, and information concerning the experimental procedure is not sufficiently detailed to permit attachment of great significance at this time. Furthermore it is essential, because of metabolic difference, to study this problem in other species where the results can be more directly applied to man. The Neals reported that 12 rabbits on high fat—high cholesterol—

hard water regime had less atherosclerosis than did 4 rabbits given similar diets with distilled water. In a later experiment 5 rabbits on the same diet, using distilled water to which magnesium sulfate had been added, showed no atherosclerosis. When three groups of 5 rabbits each were fed the same diet, one with distilled water, one with hard sulfur water, and one with distilled water to which calcium carbonate had been added, all showed atherosclerosis—most pronounced in the group of 5 on distilled water, and less in the other two groups. It would seem desirable to repeat these studies on other species of animals before entering into an extensive discussion of the findings.

Related Studies

Not directly concerned with drinking water but perhaps related to these observations is the work of Jankelson, O. M.; Vitale, J. J.; and Hegsted, D. M.,[8] who failed to find in man a correlation between the serum cholesterol and magnesium levels. Likewise, Brown, D. F.; McGandy, R. B.; Gillie, E.; and Doyle, J. T.,[9] could not demonstrate a correlation between serum magnesium levels and various lipid fractions, and they found no difference in serum magnesium levels of patients who had suffered myocardial infarction as contrasted with a clinically normal group.

In 1962, R. C. Turner[10] considered the varying amounts of dissolved inorganic material in the waters of several separate areas in England and Wales and the causes of deaths in those areas. ". . . specimens which originated in North Wales yielded very small amounts of residue after evaporation, and that by Water Engineer's standards they were very soft waters, often containing only a few parts per million of inorganic material. On the other hand, the drinking waters examined from the eastern and southern regions of England were, by the same standards, usually hard or very hard, with inorganic contents ranging up to 400 parts per million."

Turner reports that the mortality rates for vascular lesions affecting the central nervous system, appear significantly higher in both sexes in the areas where the total dissolved inorganic materials in drinking water is minimal. Arteriosclerotic heart disease also shows a slight surplus mortality, but only among the males in the areas where the dissolved inorganic materials are minimal.

Discussion

In the Proceedings, Conference on Physiological Aspects of Water Quality, Sept. 8-9, 1960, Washington, D.C.,[11] Abel Wolman pointed out that " . . . in the illustrations of the complexity of the environment, which naturally follows upon industrialization and urbanization . . . one discerns no easy principles or easy axioms. In such simple (or hitherto assumed to be simple) equilibrium as in calcium intake . . . there are pros and cons, positive and negative values. There are values of fortification in foods as well as disadvantages. The calcium, selenium, molybdenum, sulfate, copper situations all point, not to disaster, but to the fact that the physiological behavior of man is not a simple mechanism which we can evaluate in an easy slide rule effort."

In pointing out the need for specificity and accuracy Wolman[12] recalled the following example from Professor Phelps' text on Public Health Engineering.

"He has an interesting and instructive chart in the book which shows the increase in telephone poles in the United States since 1890 and the decrease in typhoid fever death rates for the same period. It is an obvious conclusion that the increase in telephone poles reduced the typhoid fever death rates. In a sense, it helped do so by better communication, by more rapid medical service, by delivery of the ambulance . . . But the direct causal relationship between the telephone poles and typhoid fever is a statistical inacurracy. . . ." .

In a consideration of the relationship of the inorganic constituents of drinking water to cardiovascular disease, it would seem essential to leave no doubt in the mind of the scientific public concerning the precise meaning of terms. For example, the term "apoplexy" includes several pathological possibilities and it would be highly desirable to have a greater degree of precision of diagnostic categories available.

The difficulties in using death certificates and even pathological reports as undisputed

evidence of the prevalence of a disease are also to be recalled. As Paul[13] has written: " . . . the differences in the precision and manner of labeling and the prioritics ascribed to pathological syndromes may well reflect diagnostic interests or fashions, such as the increased popularity of coronary oeclusion as a diagnostie label in death certificates. These exert some influence upon the recorded trends of disease incidence." A good example of the effect of "diagnostic interest" and of prccision in myocardial infarction has been reported by Söderström from Malmö[14] where he ascribed a marked and sudden increase in healed myocardial infarcts reported at autopsy to improved laboratory facilities.

The characterization of a water as "hard" or "soft" is so much a question of what one is accustomed to that to attempt a general classification is hazardous. The responsible substances are calcium and magnesium ions and to a lesser extent (because of their normally smaller concentration) those of iron, manganese, strontium and aluminum. The pseudo-hardness of brines is related to the prevention of solutions of sodium soaps by sodium ions.

By convention, water is normally considered hard when it contains in excess of 100 milligrams per liter of hardness, soft when the value is less than 50 mg. per liter.

When the total hardness is greater than the sum of the carbonate and bicarbonate alkalinity, the amount of hardness equivalent to the alkalinity is "earbonate hardness." The amount in exeess of this is "non-carbonate hardness." When the total hardness has a value equal to or smaller than the sum of the carbonate and bicarbonate alkalinity, there is no non-carbonate hardness. Non-carbonate hardness ineludes, in partieular, calcium and magnesium chlorides and sulphates, and, at times, nitrates.

It should be apparent, therefore, that gross calculations of hardness serve but little purpose in the attempt to correlate disease causation with water quality. In such studies, identification of specific anions and cations would be a required prerequisite to developing accurate relationships.

When evaluating the significance of ingested water, it is important to give consideration to the facts that Americans travel a great deal and drink water from different areas at various times of the year; that their beverages are not neccssarily bottled loeally; and that canned food made with added water, soups for example, may eome from distant areas.

Still another source of ingested inorganie material from water is that which is consumed when dried foods are eaten. For example, when dry, ready-to-eat cereals are eaten, the consumer not only consumes cereal but the inorganic ingredients of the water in which the cereal was proccssed. Water from many sources is used in the manufacturc of the commercially prepared foods.

It is an error to confuse statistical correlations and causal relationships. Statistical correlations never prove causal relationships, but a statistical correlation is useful in suggesting possibilities which may later be tested by carefully controlled research methods.

In evaluating material, the existence of an association between two factors cannot bc interpreted as evidence of a causal relationship, but it may be consistent with a causal relationship existing between the two factors. A spurious association can arise through the influenee of a third variable and both Schroder (JAMA) and Morris and associates (Lancet) have investigated the role of a third variable in producing this assoeiation. These investigators have found that the apparent negative association between the "hardness" of water and the death rate from cardiovascular disease persists after considering the effects of selected third variables. This cannot be interpreted as meaning that no third variable exists capable of produeing the association between the "hardness" of water and the death rate from cardiovascular disease because there is evidence that this latter association is spurious.

For example, suppose, as suggested by Glenn Bartsch, Division of Biometry, Western Reserve University, School of Medicine, that 48 states and Washington, D. C. are classified as to whether or not they have a sea coast, regardless of its length. If a non-spurious association exists between the death rate from cardiovascular disease and the "hardness" of water, the association should be present among the states with sea coast as well as those without sea coast. Using the data in Table 2 of Schroeder's

Figure I

Scatter Diagrams of Average Annual Age-Adjusted Death Rates of White Men Aged 45 to 64 Years from Cardiovascular Diseases (per 100,000 Persons), 1949-1951, and Weighted Average Hardness of Finished Municipal Waters, 1950-1951, by Location of State

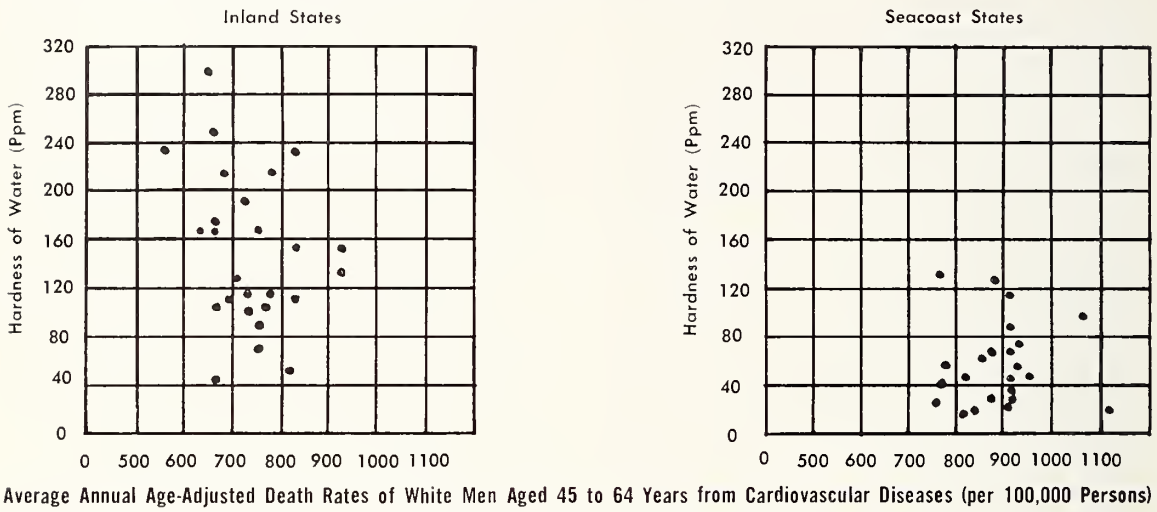


Table I

Average Annual Age-Adjusted Death Rates of White Men Aged 45 to 64 Years from Cardiovascular Diseases (per 100,000 Persons), 1949-1951, and Average Hardness of Finished Municipal Waters, 1950-1951 by Location of State

	Hardness	All causes	All causes except cardiovascular	Cardiovascular diseases	Coronary heart disease	All other cardiovascular disease
Seacoast states						
number	23					
average	56	1609	722	887	552	335
standard deviation	35	124	53	87	60	60
correlation coefficient		0.21	0.42	0.05	0.10	−0.03
Non seacoast states						
number	26					
average	151	1428	690	738	451	288
standard deviation	64	188	125	89	62	46
correlation coefficient		−0.16	−0.06	−0.26	−0.15	−0.30

5% significance level for product moment correlation r >0.413 23 pairs
r >0.388 26 pairs

paper (JAMA), scatter diagrams showing the relationship between "hardness" of water and the death rate from cardiovascular disease for the two groups of states are given in Figure I. Aside from the three points representing South Dakota, Nebraska, and New Mexico in the upper left corner of the diagram for the inland states, there appears to be no association between the "hardness" of water and the death rate from cardiovascular disease. No evidence of an association between these two factors is present in the diagram for the sea coast states either.

The product moment correlation coefficients as computed by Bartsch for each group of states are given in Table I. The correlation coefficients are small and carry both positive and negative signs. These results also indicate no evidence of an association between the "hardness" of water and various death rates once the location of the state is controlled. By comparing the means of the two groups of states, the spurious association occurred as a result of pooling heterogeneous data. The average death rate in the sea coast states is higher than those of non-sea coast states, whereas, the average "hardness" of water is lower in sea coast states than non-sea coast states.

Conclusion

The panel has concluded on the basis of available data that no causal relationship has been established between the total dissolved inorganic constituents of drinking water and cardiovascular disease. It is abundantly evident that the minor constituents of food, water and the air are capable of influencing human physiology most profoundly. Well known examples include iron in anemia, iodine in goiter, and fluorine in dental decay. The concentration of inorganic constituents is much greater in foods than in water, but the sum total of the constituents make all sources important.

Further work on the potential role of inorganic constituents of water on cardiovascular disease, if undertaken, should involve the study of comparable populations in which the water supply with respect to one or more given constituents is controlled. The length of time an individual is on a given water supply must also be taken into consideration. Uniform criteria for diagnosis must be established, and the study must be continued over a period of years in order to obtain a definite answer.

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Esostoses, Chondrodysplasias, and Dyschondroplasias

An Attempt To Clarify

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Although many excellent monographs and books have been published about osseous and cartilagenous growths affecting bone—the average practitioner is often plagued with a deluge of conflicting terminology and verbiage. This brief tretise will attempt to define and organize the existing confusion.

We are basically concerned with two growth types—those which are bony and those which are composed of cartilage. These growths may be either outside the cortex of the bone (extracortical) or inside the bone (medullary).

This missive is concerned primarily with three such peculiar growths. First, there are the solitary exostoses, we then have the multiple or hereditary exostoses, and finally the enchondromatoses.

Solitary Osteocartilagenous Exostosis

Definition: This is the most simple type of bony growth. As the name implies it is single and composed of bone and cartilage—the cartilage forming a cap or hood over the spur of bone.

Synonyms: Solitary osteochondroma, osteochondroma, exostosis.

Type and Location: The solitary exostosis may be either sessile or stalked and is usually located on the lower femur, upper tibia, upper humerus, and lower radius—only in bones preformed in cartilage. The exostosis is usually directed shaftward away from the bone-end and is located just next to the area of growth at the end of long tubular bones.

Age and Sex Incidence: The growths are usually noted in young children and teenagers with the sexes being equally affected.

Clinically: The patient or a parent usually notices the lump or spur by accident. Occasionally it is bumped at play. Rarely the growth impinges on a nerve or blood vessel causing specific symptoms.

Size: The average exostosis measures three to five centimeters in diameter at its base but can range from one to ten centimeters.

Externally: The exostosis is covered with periosteum continuous with the cortex of the bone. A cartilage cap is almost always present and is larger in younger children. This cap is important because it cannot be seen on x-rays and the size of the exostosis may thus be misleading. Occasionally an adventitious bursa forms over the entire exostosis.

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Figure 1

Solitary osteocartilagenous exostosis of the distal right femur in a 17 year old boy. The lesion was first noted by the patient at the age of 10 when he bumped it at play. Because of its continued growth and repeated trauma to the area it was removed.

Internally: The exostosis is composed of spongy bone with gritty foci beneath the cap made up of partially calcificd cartilage.
Activity: By far the great majority of exostoses are benign—at least 99 per cent. A rapidly growing exostosis is suggestive of malignancy.
Treatment: Consists of surgical removal only if the growth causes difficulty from pressure, pain, or a rapid increase in size occurs. The periosteal covering should be completely removed. In cases of malignancy—amputation is justified. (Sec figures 1 through 4).

Hereditary Multiple Osteocartilagenous Exostoses

Definition: As the name implies, these anomalies of skeletal development are hereditary (approximately 50 per cent of all offspring having the condition). They are also multiple and usually symmetrical.
Incidence: This is considered to be the most common of all systematized anomalies of skeletal development encountered clinically.
Age and Sex Incidence: The average age of discovery is during early childhood. Males are affected twice as often as females.
Type and Location: In general, the growths are sessile—not stalked. They are found mainly in the knee region—distal femur and proximal tibia. They are also found in the scapula, humerus, forearm bones, pelvic girdle, and ribs.
Clinically: The patient usually presents in child-

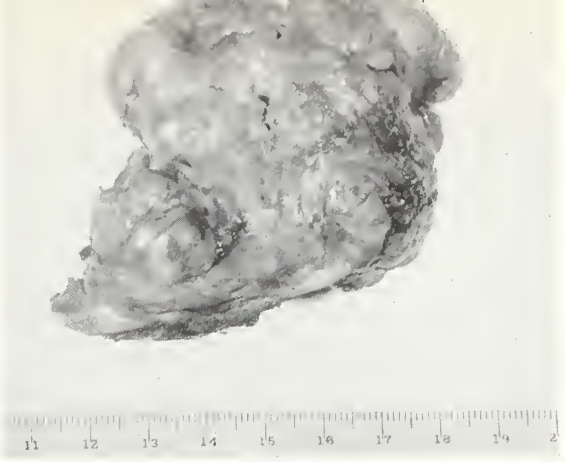


Figure 2

Solitary exostosis seen after removal from the right ileum of a 20 year old white female. This lesion was removed because of its location and continued growth.

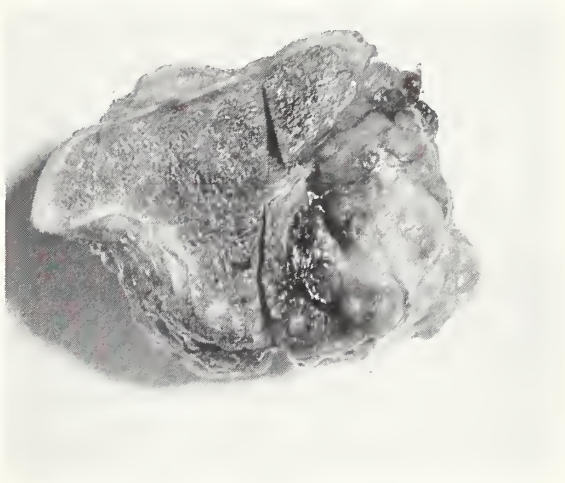


Figure 3

The same lesion as in Fig. 2 split longitudinally. Note the soft tissue covering and the cartilagenous cap.

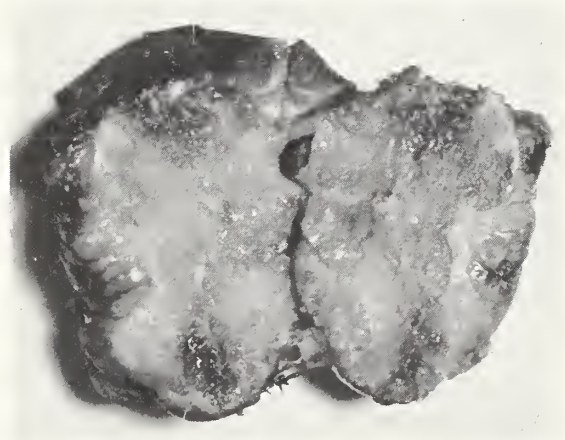


Figure 4

Same lesion as in Figs. 2 & 3. In this section, the exostosis can be grossly seen to contain spongy bone with gritty cartilagenous foci. This bone is covered by a cartilage cap and adventitious bursa.

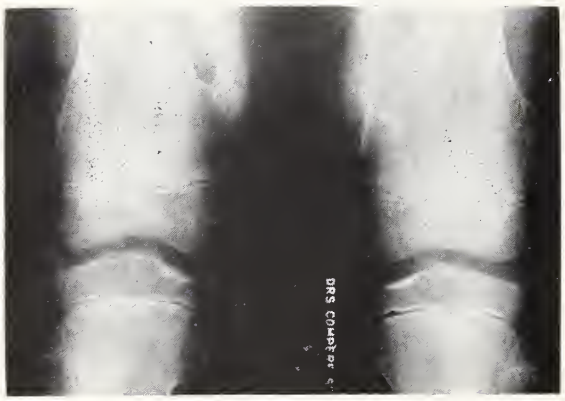


Figure 5

Hereditary multiple osteocartilagenous exostoses of the distal femora and proximal tibiae in a 14 year old white male with a familial history of similar growths affecting his mother and three of his five siblings.

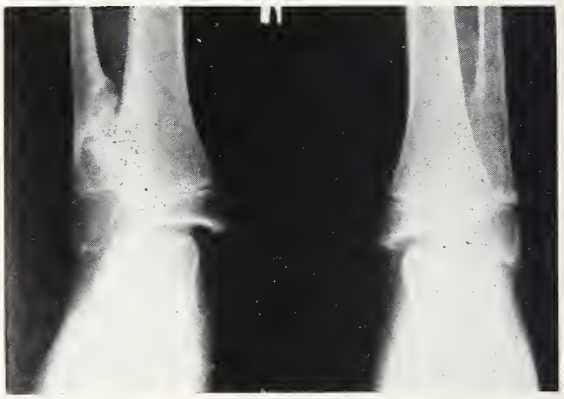


Figure 6

Same case as Fig. 5 showing involvement of the distal tibiae and fibulae.

hood with multiple painless lumps, pressure from specific involvement of nerves or blood vessels, or a bowing of the forearm with ulnar deviation of the hand. The limbs are usually short and the patient exhibits the appearance of a mild achondroplastic dwarf. Pathologically these lesions are identical to solitary exostoses except that they are larger and more numerous.

Heredity: Since this is considered by some to be a sex-linked recessive characteristic, females transmit the disorder to their children even though they themselves may not exhibit the condition. An unaffected male in a family tree, however, does not transmit the disorder to his children.

It is also interesting to note that the number of children affected (approximately 50 per cent) is just as great when the condition is transmitted from an unaffected mother as when through an affected mother. Other observations have shown that people with few exostoses will usually have children with approximately the same number. Also, in any given family tree the exostoses tend to be more numerous from generation to generation.

Activity: Although the vast majority of multiple exostoses are benign, reports in the literature record as high as 20 per cent transformation into chondrosarcoma. This is higher than most authors report and certainly has not been true in the authors' experience. It is believed that the malignancy arises from the cartilagenous cap. The most common location is at the hip joint in adults. This is usually a slow growing tumor with a course of 2-10 years with only occasional metastases.

Treatment: Consists of removing only those growths causing trouble or which grow suddenly to a large size. The entire periosteal layer should be removed. If malignancy is noted amputation is the treatment of choice—if possible. X-ray therapy being of little value. (See figures 5 and 6).

Synonyms: We now enter the most confusing area of terminology ever perpetrated on the student—the many terms of "Hereditary Multiple Osteocartilagenous Exostoses." Since the literature is crowded with an interchange of these synonyms they must be learned.

1. *Diaphysial Aclasis:* This is a British term which points out that the modeling of the entire bone area is abnormal. The term emphasizes pathogenesis to the exclusion of clinical appearance. It should be replaced by "multiple exostoses" which described the lesion so well.
2. *Hereditary Deforming Chondrodysplasia* (or just Chondrodysplasia): This former American name creates no mental picture of the disorder and should be discarded.
3. *Osteogenic Disease:* This is a French and Italian name originated to fit the existence of:
   a) multiple exostoses alone,
   b) multiple enchondromatosis alone,
   c) the two conditions together.
   This term causes great confusion and should be deleted since the two condi-

tions referred to are completely separate disorders.

4. *Dyschondroplasia:* This term was coined by Ollier and is unfortunately very similar to chondrodysplasia—but not at all the same. It is considered by most authors to be synonymous only with multiple enchondromatosis.

Multiple Enchondromatosis

This infrequent disorder is characterized by the presence of circumscribed foci and/or large masses of cartilage in the interior (or medullary cavity) of several or sometimes many bones of the body. Usually the involvement is greater on one side of the body than the other.

Etiology: The cause is obscure. There seems to be no hereditary or familial influence, but several features—notably the selective rather than generalized involvement of the epiphyses, normal blood chemistry, and an occasional association with congenital hemangiomata—support the view that it is the result of a primary germ cell defect. Some authorities feel that it is a form of Vitamin D resistant rickets.

Synonyms: Here again disorder and confusion exist. The most appropriate synonym is:

1. *Dyschondroplasia (not, Chondrodysplasia):* This term correctly suggests that this is a developmental defect relating to cartilage. It is considered to be synonymous with multiple enchondromatosis by most authors. However, some writers believe that the term "dyschondroplasia" is a more general term encompassing not only multiple enchondromatosis but also hereditary multiple osteocartilagenous exostoses and other osteo-cartilagenous disorders.
2. *Ollier's Disease:* is a term usually reserved for cases of multiple enchondromatosis confined to one side of the body—as originally described by Ollier in his four cases presented in 1899.
3. *Maffucci's Syndrome:* is multiple enchondromatosis plus multiple hemangiomata and phlebectasia in various soft parts.

Age and Sex Incidence: This disorder is usually noted in early childhood around the age of two. Males are generally affected more often.

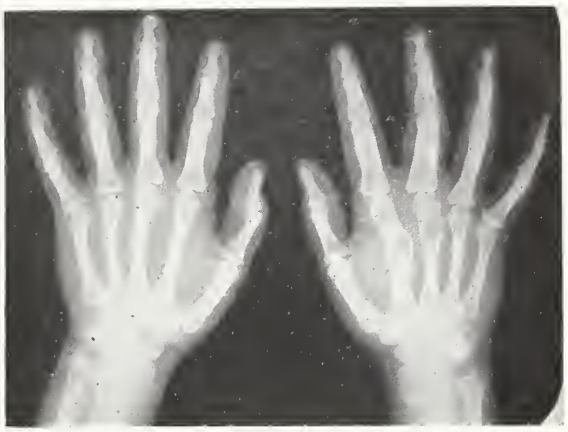


Figure 7

Multiple enchondromatosis in an 18 year old white female. Note the involvement of the metacarpals and phalanges of the 2nd and 3rd rays of the right hand. This was the only area in the body so affected and required no treatment. The left hand was perfectly normal. Accordingly, this is a case of Ollier's disease—multiple enchondromatosis confined to only one side of the body.

Clinically: These patients usually present with pathological fractures, bowing of the forearm with ulnar deviation of the hand, and occasionally dislocation of the head of the radius. Very often the child will limp due to unilateral lower limb involvement and may have knock knees or bowlegs due to retarded growth of the femurs or tibiae.

X-ray: In advanced cases there is usually bulging on one side of the bone-end, especially at the metaphyseal regions. In those regions there are sometimes one or several septa running in the long axis of the bone. As the patient becomes older these radiolucent septa come to involve the epiphyseal areas and spread out—especially in the pelvis to form fan-like striations.

Gross Pathology: The long bones affected are short and bowed with broadening at the metaphyseal regions. The medullary canal is found to be occupied by numerous bean-shaped masses of confluent cartilage separated by bony septa. Joint spaces are almost never involved.

Activity: Chondrosarcomas occur usually at middle age in approximately 50 per cent of all victims. It is interesting to note that chondrosarcomas may develop in a very slight case just as easily as in a very severe case.

Treatment: Consists of repairing pathological fractures which develop. Occasionally bone-grafting will be necessary to obtain union.

There is no treatment except amputation (where possible) for cases of chondrosarcoma. X-ray therapy is of little help. (See figure 7).

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The Uncooperative Patient in Obesity

Frank L. Bigsby, M.D., and
Cayetano Muniz, M.D., *Chicago*

Practicing Physicians may unwittingly contribute to a situation in the realm of obesity in which a limited portion of patients may dictate professional thinking and therapy. This stems from the fact that there exists rather constant numbers of overweight Americans blessed with certain basic physiological and psychological traits that are consistent with sustained dieting. The individuals possessing adequate degrees of these features may well be less than half the total of those considered overweight. This unknown aggregate of patients may become the basis for an over-simplified classification of the obese: 1. The cooperative patient, and 2. The uncooperative patient. The mediocrity of this classification should not be considered lightly. Actually, such a classification has been advanced and in itself is evidence of a startling lack of understanding of obesity.

How does it become possible for what may be a minority of patients to formulate obesity therapy? Many specialists in medicine, surgery, and general practice are of the belief that the real or implied threat of an overhanging medical anomaly is all that is required to cause the obese patient to toe the dietary line. This certainly may be true of the cooperative patient. But what of the uncooperative obese type? Does the physician always have the time, the patience, and the interest to consider his plight, and does he realize the deeply ingrained need for physician dependency the obese patient may possess? If not, this unfortunate may become a medical outcast and be relegated to the vast roving army of obese people going from reducing salon to reducing salon, food faddist to food faddist, one over-the-counter preparation to another, or reading the misleading information such as we now come upon between the covers of the flood of books recently added to diet literature. The cooperative patients are responsible for the popularity of this wide assortment of reducing aids as great numbers are able to lose impressive amounts of adipose tissue regardless of the method chosen. The uncooperative patient, contrariwise, may try every method with nothing but failure and may accordingly be forced to shift for himself in a world of conflicting ideas and statements in quest of a solution to his perplexing problem.

At the opposite level of the ethical scale is the isolated instance of the medical charlatan who capitalizes in a vastly different manner on this same assemblage of cooperative obese patients. Many in the medical world believe that the charlatan treating obesity preys on the innocent and uninformed layman. This is not the case as the charlatan is happy with the cooperative patient finding the way to his office and, although he is apt to possess less knowledge of the problems of the obese than that shown at other ethical levels, he willingly exploits the cooperative patient's built-in characteristics insuring a certain degree of weight loss regardless of type of treatment. By stressing the efficacy of his management, under-stressing curtailment of calories, and fostering the notion that he is the sole local representative of a nation-wide organization owning rights to magic medication with the power to 'burn fat', the charlatan promotes his practice. This group of cooperative patients, the same favored by the specialist, thus becomes the nucleus of a land-office business. There are always sufficient stories of fabulous results, sans dieting, floating about the community to insure a flood of patients and monetary success. It is entirely possible that the numbers of patients succeeding in weight loss under the direction of the two extremes of medical philosophy might approximate each other.

It is apparent that the uncooperative patient becomes the real victim. On the one hand the physician may be short tempered and short sighted, thus unwittingly advancing an already disagreeable situation. The other extreme could not care less for this patient and may tend to temporarily deter cessation of treatment by the only methods available, a good desk-side manner and the promise of stronger and more magical medication to come.

Traditionally, the medical charlatan in obesity has been attacked by individual physicians and by policing bodies at the local, state, and national levels. There may be figures available to show the futility of this approach. As with most problems, the solution rests in education. In this instance more comprehension of obesity must be acquired in order to discourage the ever increasing numbers of obese medical outcasts.

To facilitate early recognition of patients who will require understanding care from the outset of therapy a breakdown of major features of some of the common obese types recognized by the authors in their practice may be beneficial[1] (Table 1). Various manifestations serving to alert the physician to the possible presence of an uncooperative patient will be noted by asterisks. It should be stressed that the following breakdown of features is for the sole purpose of this paper, that there is no attempt made to depict a complete clinical picture of each obese patient-type.

A review of the features before which asterisks have been placed discloses that the familial, gastronomic and puberal obesities are

Table 1

Classification	Major Features
A. **Familial Obesity:**	
	*1. Motivation poor.
	2. May snack at any hour on social basis rather than tension outlet.
	3. Degree of actual obesity often highest of all types.
	4. Rapport good.
	5. Physiological tension infrequent.
	6. Emotional tension infrequent.
	7. Calorie pattern often follows pattern of entire family, food is center of family social life.
	8. Prognosis fair.
	9. Insight adequate.
	10. Often good cooks and enjoy own cooking.
	11. Other than housekeeping activities usually leads sedentary existence.
	12. Often presents small skeletal and muscular systems.
B. **Gastronomic Obesity:**	
	1. Eats slowly.
	2. Rarely snacks.
	3. Desire for sweets not a factor.
	4. Emotional tensions negligible.
	5. Physiological tension minor.
	6. Overweight not severe.
	7. Prognosis fairly good.
	8. Rapport good.
	9. Usually not copious liquid drinkers; often take wine with meals.
	10. Eating pattern most regular.
	11. Insight good.
	12. A real gourmet with interest in quality rather than amount of food.
C. **Puberal Obesity:**	
	1. Age diagnostic.
	2. Eating pattern can be average for age group; can become developmental obese type if compulsive eating pattern becomes evident.
	3. Rapport average.
	*4. Motivation frequently lacking at onset.
	5. Predilection for carbohydrates.
	6. Weight range in middle and higher levels.
	7. Prognosis good with onset of motivation (usually interest in opposite sex).
	8. Usually quite stable for their age.
	9. Usually have secure home environment.
	10. Present pronounced muscular and skeletal development.
D. **Night-Eating Syndrome:**	
	*1. Rapport often poor.
	2. Poor nutritional habits.
	3. Insomnia prevalent.
	*4. Physiological tension high.
	*5. Emotional tension high.
	*6. Prognosis poor.
	7. Heavy sweet intake always a factor.
	8. Often heavy coffee drinker and smoker.
	9. Weight range highly variable.
	10. Typical tension night eater, starts snacks immediately after dinner.
	11. 3 types: (a) typical tension night eater; (b) 10 P. M. snacks; (c) late-late eater.
	*12. Lacks insight.
E. **Constant Compulsive Eater:**	
	*1. Emotional tension extreme.
	*2. Physiological tension high.
	3. Often in upper weight range.
	4. No organized eating habits.
	5. Snacks on any available food, sweets and starches only because of availability.
	6. Often drink excessive liquids.

almost devoid of elements likely to promote the obese outcast. The night eater, the constant compulsive eater, the developmental and extreme obesities, on the other hand, are liberally supplied with asterisks.

The specific features figuring prominently and serving to alert the physician include emotional tension states, physiological tension states, status of rapport, degree of motivation, status of insight, and prognosis for weight loss.

1. Emotional tensions promote the compulsive eating pattern and highly disorganized mode of living that makes sustained dieting difficult.

2. Physiological tensions may produce repeated severe episodes of drug reactions from anorectic preparations causing early cessation of therapy and eventual assignment to the obese outcast group.

7. Eat without appetite.
*8. Rapport poor.
*9. Motivation poor.
10. Prognosis fair.
*11. Insight poor.

F. **Developmental Obesity:**
1. Onset in adolescent years.
*2. Emotional tension prevalent.
*3. Motivation low.
4. Day and night compulsive snacks.
*5. Rapport often poor.
*6. Prognosis poor.
7. Usually quite overweight in addition to large skeletal and muscular systems.
8. Inability to tolerate frustration or delayed gratification.
*9. Physiological tension high.
10. No regular eating pattern.
11. Misunderstandings and frequent emotional episodes concerning calories are the rule at home.
*12. Lack insight.

G. **Extreme Obesity:**
1. The 300 pounder.
2. An added factor is constitutional bigness.
*3. Presents immobile facial response; rapport not obtained.
4. Negative resistance to all approaches.
*5. Motivation very poor.
*6. Prognosis probably poorest.
7. Dietary pattern difficult to determine.
*8. Emotional and physiological tension present but not discernible.
*9. Degree of insight a mystery.

***Manifestations of possible uncooperative patient.**

3. Faulty rapport is frequently encountered in the teen-age obese patient and may stem from the fact that the youngster is forcibly led to the physician's office. Manifestations of altered rapport also arise from repeated failures in past attempts to reduce and to maintain weight loss.

4. Poor motivation is perhaps the most glaring deficiency encountered in the management of the obese patient. Immediate cosmetic improvement, not health, is the frequent pressing issue. The physician must recall that proper incentive to reduce involves a reward that the patient expects in restitution for calorie sacrifices. When such reward is not immediately forthcoming motivation to reduce is short-lived.

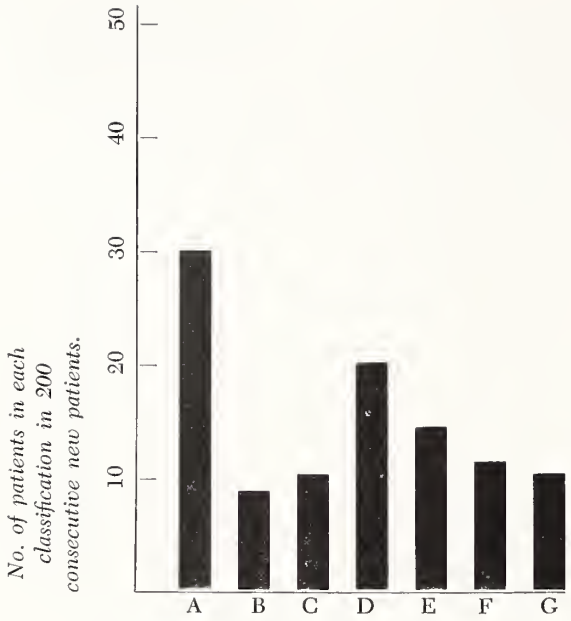
5. The low degree of patient insight into the true nature of the psychological and physiological factors influencing body weight is often difficult for the physician to comprehend. The mistaken ideas may arise from lack of knowledge or from misdirection in previous reducing regimen.

The physician must acquire the ability to sense the status of rapport, motivation, and insight; the presence, absence, and degree of any combination of this triad of factors seriously affects gaining a cooperative patient.

6. Poor prognosis for weight loss is a feature most difficult to combat. The uncooperative patient commonly demands early and dramatic results and the physician often yields by resorting to extreme calorie measures, potent anorexiants, diuretics, and other agents designed to promote instant but temporary weight loss. Serious analysis will reveal that the physician is playing into the hands of the patient by being compliant and is but contributing to the faulty insight so typical of the obese medical outcast.

To afford an idea of the frequency with which the obese classifications appear in private practice the authors found 30 of 200 consecutive new obese patients were familial obese, 6 gastronomic obese, 8 puberal obese, 20 night eating syndrome, 15 constant compulsive eater, 12 developmental obese, and 8 extreme obese. (Fig. 1)

Finally, the physician must learn to recognize the uncooperative obese patient and devote to him more time, display more patience



Classification of Obese Types discussed in article

Key:
A. Familial Obesity.
B. Gastronomic Obesity.
C. Puberal Obesity.
D. Night-Eating Syndrome.
E. Constant Compulsive Eater.
F. Developmental Obesity.
G. Extreme Obesity.

and understanding, and afford individualized therapy from the outset. Individualized therapy implies thorough patient indoctrination as to general education, caloric education, surface psychotherapy within the domain of one's interest and training and, when indicated, the judicious use of physical exercise and pharmaceutical agents.

Summary

1. The uncooperative obese patient presents features making weight loss from any reducing regimen difficult, if not impossible.

2. Early differentiation between uncooperative and cooperative obese patients is required and can be readily accomplished when considered from the viewpoint of definitive clinical classification.

3. Some of the obese types commonly seen in clinical practice are cited and their major characteristics that may serve to alert the physician to the presence of a problem patient are defined.

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Used Equipment Can Save Lives

Hospital and medical personnel in foreign countries often are seriously handicapped through lack of equipment and supplies. Much material that has been superseded here by newer designs could save lives if put to use elsewhere. Hospitals and individuals wishing to contribute usable but no longer needed medical and hospital equipment for shipment to India are asked to contact Jose Gonzalez, M.D., director, International Hospital Program, American Hospital Association, One Farragut Square South, Washington 6, D.C. He will arrange with the appropriate agencies for pickup services and overseas shipment. Present needs are for clinical laboratory and occupation therapy equipment, maternal and infant care equipment and furnishings (incubators, resuscitators, anesthesia machines, suction machines, sterilizers, dressing carts, etc.), general furniture items for housing, waiting room areas, medical books, etc.

IMJ Case Report

Functioning Carcinoma of the Adrenal Cortex

Frank B. Norbury, M.D., *and*
Thomas L. Wilson, M.D., *Jacksonville*

There Has Been Increasing Interest in the study of hyperfunction of the adrenal cortex since the advent of cortisone which has made adrenal surgery feasible and safe. Newer diagnostic tests and intensive hormone analyses of cases have shed light on adrenal physiology and pathology. Cases of cortical hyperfunction can be divided into two extreme groups, Cushing's syndrome[1,2] and the adrenogenital syndrome.[3] Not all cases fit clearly into one group or another, and mixed forms are being recognized in increasing numbers.[4,5] Functioning tumors, especially malignant tumors, of the adrenal cortex are prone to present as mixtures of Cushing's syndrome and the adrenogential syndrome.[6]

Case Report

This 35-year-old married woman was first examined because of complaints of dizziness, headaches, nausea, and anxiety of three months' duration, and amenorrhea of seven months' duration. She had been in good general health in the past although her blood pressure had been noted to be elevated transiently about one year before, and there was a history of pleurisy and pneumonia contracted in childhood in England. She was a war-bride who had survived the "blitz" and was happily married with two children, ages 15 and 10.

Examination showed her to be a thin, pleasant, shy, youthful-looking young woman. She was moderately anxious and tremulous without obvious reason. Her blood pressure was 190/120 and the fundi showed moderate A-V nicking. She had marked striation of the abdominal wall, but these striae were old, nonpigmented, and had the appearanee of those whieh are seen following pregnancies. There was no ankle edema, or edema elsewhere. The hair distribution was normal and patient had noted no ehange it it. There were no abnormalities on pelvic examination.

Her hypertension had persisted despite the use of sedation and hydroehlorothiazide. It was therefore decided to proceed with further investigation of possible eauses of hypertension. An intravenous phentolamine (Regitine®) test was performed and this was negative. An intravenous pyelogram was ordered, but the patient complained of dizziness and itching at the beginning of the injection of the dye and therefore the proeedure was abandoned. The plain film taken before pyelography showed a mass in the left kidney region.

Our Saviour's Hospital, Jacksonville, Illinois

Laboratory examination

Blood counts:

HB 14.5 gm.; WBC: 9,400; Lymphs 8; Monos 2; Eos 0; Segs 80; Stabs 10.

Blood chemistry:

Urea Nitrogen 11 mgm%; Fasting Blood Sugar 90 mgm%; Serum Sodium 140 meq/L; Potassium 3.6 meq/L; Chlorides 96 meq/L.

Hormone studies:

Protein bound iodine 5.0 mierograms%; Urinary catecholamines 5.4 mierograms (Normal 0-14); Urinary 17-Ketogenie Steroids (17-hydroxysteroids and 11-oxysteroids by the Norymberski method) 115 mgm/24 hours (Normal 6-15); Urinary 17-Ketosteroids 34. mgm/24 hours (Normal 7-15).

In the hospital, her hypertension was not eontrolled with medieation. A retrograde pyelogram was performed and the patient was found to have a mass in the left upper quadrant displaeing the left kidney inferiorly and medially. There was also downward displaeement of the right kidney and some rotation of the kidneys. X-rays showed no evidence of osteoporosis.

After the mass was detected on pyelography, the patient was prepared with cortisone for several days and then operated on through a left flank ineision. At operation, she was found to have a mass, approximately 15x14x9 centimeters in size, proximal to the upper pole of thc left kidney. It could not be eompletely separated from the kidney and the main artery to the tumor was shared with thc upper pole of thc kidney; therefore, the mass and the left kidney were removed together. On cut section, the mass presented as a hemorrhagie gray cystic strueture with masses of yellow necrosis. Mieroseopic examination showed it to be eomposed of a granular alveolated pattern with polygonal eell elusters and necrosis.

Post-operatively, the patient eontinued to show marked hypertension and elevation of the 17-ketosteroids despite cortisone administration. For these

reasons and the X-ray appearance of displacement of the right kidney as well as the left, it was decided to explore the right side also. At the time of the second operation, the right kidney and right adrenal gland appeared normal, but there was a mass in the right flank pushing out the peritoneum. The peritoneum was incised and this mass was found to be a tumor in the liver. There were numerous tumor nodules in the liver and biopsy of one of these showed it to be a metastasis from the tumor of the left adrenal.

The patient's immediate post-operative course was satisfactory, although the incisions did not completely heal. She went home, but returned two months later with marked enlargement of the liver and ascites. She still had elevated blood pressure, had lost more weight, and had developed hirsutism of the legs and face. She wished to return to her own community for terminal care, and therefore she was discharged. Death occurred at home three weeks later. No autopsy was obtained.

Discussion

This unfortunate young woman originally presented as hypertension and anxiety and it was in the course of a diagnostic study for hypertension that the clues to her underlying disease were found. With increasing use of tests of renal and adrenal function in the study of hypertensives, it is likely that more of these cases will be discovered.[7,8]

Functioning carcinoma of the adrenal gland is not a common disease. In the series reviewed, the incidence of carcinoma in cases of Cushing's syndrome was between 10 per cent and 15 per cent. Except for one case which lived three and a half years, all of the tumors reported have shown a high degree of malignancy with a rapidly fatal termination.

This case would not be easily recognized as either Cushing's syndrome or the adrenogenital syndrome from clinical observation alone. She did not have the habitus of Cushing's syndrome or the virilization of the adrenogenital syndrome. Of the common features of Cushing's syndrome, this patient showed hypertension, amenorrhea, muscular weakness, mental disturbance, and acne. Poor wound healing and hirsutism appeared later in her course of illness. She did not show obesity, bruising, edema, moon-face, or osteoporosis. Her striae were not characteristic of Cushing's syndrome.

From the laboratory standpoint, she did not show polycythemia, hyperglycemia, or hypokalemia. She had marked elevation of both the 17-Ketogenic steroids (17-hydroxy and 11-oxycorticoids) and the 17-ketosteroids indicating increased production of both corticoid and androgenic hormones.

Carcinoma of the adrenal gland can be diagnosed pre-operatively from certain features which differentiate it from adrenal hyperplasia and from benign tumors. These features are:

1. An atypical clinical picture with a mixture of Cushing and adrenogenital features.
2. Greatly increased 17-ketosteroid excretion.
3. Failure of the 17-ketosteroid level to fall after treatment with cortisone or ACTH.
4. Presence of a visible mass above the kidney on the plain roentgenogram or displacement of the kidney as seen on the pyelogram.[9]

Summary

A case of carcinoma of the adrenal gland with metastases to the liver has been reported. This patient's presenting symptoms were hypertension, anxiety, and amenorrhea. Both on clinical and laboratory examination, she showed features of a mixture of the Cushing syndrome and the adrenogenital syndrome. From review of similar cases in the literature, it is concluded that this mixed clinical and laboratory picture is characteristic of functioning malignant tumors of the adrenal gland. The presence of malignancy can be suspected before operation by these findings, by the response to hormone tests, and by the x-ray findings.

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The View Box

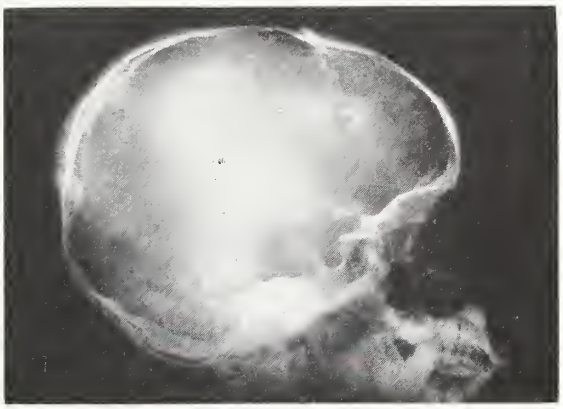
Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital



Case 1 Fig. 1



Case 1 Fig. 2



Case 1 Fig. 3

This 10 year old, Negro male entered the hospital on his 9th admission complaining of a high fever, eough and blood tinged sputum. He had had reeurrent bouts of joint pains, severe abdominal pain, lassitude and skin uleers.

Physieal examination revealed a markedly debilitated ehild with multiple deep uleers of the legs and icteric selera. He was dyspenie and had bronchial breathing over the left lower lobe. The heart was enlarged on pereussion. The ehild's hips were painful on flexion. The spleen was enlarged.

Laboratory finding: RBC 2,000,000 with increased retieuloeytosis.

What is your diagnosis?
1) Metastatic disease of bone and lung
2) Sickle cell S-S disease
3) Renal rickets
4) Sarcoidosis

(Continued on page 58)

Eosinophilia in Perennial Allergic Rhinitis

Leon Unger, M.D.,* Donald Lee Unger, M.D.,** Joanne A. Klein, M.D., *Chicago*

Perennial allergic rhinitis is a very common condition. The main complaint is prolonged nasal obstruction (a "stuffy" nose). Both nostrils may be blocked or the obstruction may alternate from one side to the other. Rhinorrhea, sneezing and itching may also occur. Epistaxis is rather frequent in children. The eyes are rarely affected.

Polyposis tends to follow persistent edema. By its very weight the boggy nasal mucosa may sag more and more and then this mucosa is polypoid. If the sagging is severe, actual polyps appear and may become so large as to obstruct the nasal openings. The sense of smell is usually diminished with this edema, but may return to normal under allergy management, especially if one of the cortico-steroid hormones is added. The sense of taste is rarely affected.

Diagnosis

The diagnosis of perennial allergic rhinitis usually is rather simple. The patient is allergic, his family may be allergic, he himself may have other allergies, his skin tests usually are positive, and his nose looks allergic.

When the nose is examined, (a) the room must be dark; (b) the examining light should be strong; (c) the nasal speculum should be as wide as possible; (d) dilatation by a spray may be necessary, e.g. ¼ per cent Neo-synephrin; (e) material for the nasal smear is collected before the spray is used.

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**Clinical Associate Department of Medicine (Allergy) Stritch School of Medicine Loyola.

The nasal smear is usually gathered by having the patient empty his nostrils into a square of cellophane (6 x 6 inches). The material is then fixed on a slide and stained with the Wright, Giemsa or Hansel stain. An applicator may be tried if the patient cannot empty his nostrils, but if the nostrils are dry, nasal eosinophilia is frequently low or absent.

Eosinophilia occurs in both the nasal smear and blood, but it is temporarily decreased by an acute coryza or by the use of antihistamines or corticosteroids.

The diagnosis is also aided by the history of prolonged nasal obstruction and by positive skin tests which can be clinically correlated to symptoms.[1]

Eosinophilia

French K. Hansel[2,3] has repeatedly pointed out that in perennial allergic rhinitis the nasal mucosa and the lining of the paranasal sinuses are usually pale and edematous and often glistening in appearance. He also demonstrated high percentages of eosinophiles in nasal smears from such patients, percentages varying from 5 to 100 per cent.

Our own observations over many years have fully confirmed Hansel's findings. In the present study we selected the last 200 patients with this condition. We compared the percentages of eosinophiles in their blood and in their nasal secretions. Almost all of these patients had pale boggy nasal mucosas. A few showed only pallor.

Table I shows this comparison, with an average blood eosinophilia of 6.34 per cent. By contrast the average nasal eosinophilia was 33.37 per cent. It is obvious that in diagnosis

TABLE I

BLOOD and NASAL EOSINOPHILIA in PERENNIAL ALLERGIC RHINITIS (200 Cases)

119 Males—81 Females	
Average Age—19.2 Years	
Blood Eosinophilia: Average	6.34%
Nasal Eosinophilia: Average	33.37%

TABLE II

OTHER FINDINGS in 200 PATIENTS with PERENNIAL ALLERGIC RHINITIS

Patients with Perennial Allergic Rhinitis only	25 cases
Patients with complicating Bronchial Asthma or Hay Fever or both	175 cases
Patients with definite nasal polyps	14 cases

TABLE III

CLINICALLY IMPORTANT POSITIVE SKIN TESTS (SCRATCH & INTRADERMAL)

Pollen	146
House Dust	134
Fungi	128
Epidermals	45
Insects	10
Foods	7
(plus 30 patients with positive intradermal tests for yeast)	
Other Inhalants	12
Total Important Positive Skin Tests:	482

the nasal smear eosinophilia is much more important that is the blood eosinophilia.

Other Observations in this Series

Table II gives other statistics:

119 males, 81 females.

Average age was 19.2 years.

Only 25 of the 200 patients had uncomplicated perennial allergic rhinitis.

The other 175 patients had associated bronchial asthma or hay fever, or both.

Definite nasal polyps were seen in only 14 cases.

Table III discusses clinically important positive skin tests, done by both scratch and intradermal techniques.

In these 200 patients there were 482 clinically important positive skin tests. Most of the patients seemed to be affected by more than one inhalant or food substance to which they were exposed over a long period of time, e. g. house dust, cats, dogs, pollen and fungi. Those with simple ragweed hay fever rarely exhibited prolonged nasal edema—this because each year ragweed-sensitive patients have about 46 weeks of freedom from exposure, and therefore the nasal mucosa usually returns to normal before the next hay fever season.

Note that foods seemed responsible in less than 5 per cent of cases.

Summary

1. Perennial allergic rhinitis is very common.
2. It may occur alone, but usually is associated with bronchial asthmas and/or hay fever.
3. The diagnosis is suspected when there is a history of prolonged nasal obstruction or rhinorrhea, and by the finding of the pale boggy nasal mucosa.
4. In 200 cases the nasal eosinophilia averaged 33.37 per cent, whereas eosinophilia in the blood only averaged 6.34 per cent.
5. Skin tests (scratch and intradermal) seemed clinically important in almost every case. The order of frequency was pollen, house dust, fungi, epidermals, insects and foods.

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Intestinal Bleeding in Lymphoma with Abnormal Proteins

Edsel K. Hudson, M.D., and Neil S. Cherniack, M.D., *Chicago*

Uncommonly considered in the differential diagnosis of severe gastrointestinal hemorrhage are the dysproteinemias.[1] This term includes myeloma, macroglobulinemia, cryoglobulinemia, and lymphomas which often overlap in their clinical and laboratory definition.[2] The following case of lymphosarcoma is presented because of the unusual manifestation of catastrophic gastrointestinal hemorrhage and the finding of a homogenous gamma-globulin peak, Bence Jones proteinuria and cryoglobulinemia.

Case Report

A 50 year old white man was admitted on May 29, 1961, because of bright red rectal bleeding. In July, 1960, he began having anorexia, bloating and occasional episodes of watery diarrhea. Four months before admission he noted black stools and two months later he began having diarrhea with bright red blood. An upper gastrointestinal series at this time demonstrated a peptic ulcer for which he was discharged on an ulcer regimen after receiving three pints of blood. Since that time the rectal bleeding continued and the patient became much weaker.

From the Department of Medicine, University of Illinois Research and Educational Hospitals, Chicago, Illinois

He had had no other elicitable symptoms except for a sixty pound weight loss in the previous ten months. There was a history of heavy drinking for many years and he had been treated for syphilis at age 35.

Examination revealed a pale middle-aged man with evidence of considerable weight loss. The tongue appeared enlarged. The abdomen was slightly distended and tympanitic and bowel sounds were active. There was dullness to percussion in the hepatic area which extended 4-5 cm. below the right costal margin. Rectal examination revealed no abnormalities but the portion of the stool withdrawn on the glove was guaiac positive. Proctoscopy was normal except for bright red blood seen coming from above the 25 cm. level. There were palpable nodes in the left axilla and a large transilluminable enlargement of the right scrotum.

Laboratory Data: Hemoglobin 8 gm., white blood cells 13,600 with 40 neutrophils, 54 lymphocytes and 6 monocytes; platelets 319,000; clotting time (Lee-White) 25 minutes; bleeding time (Duke) 6 minutes. Bone marrow examination showed normoblastic hyperplasia with some increase in lymphocytes and plasma cells. The BSP was 5.5%; SGOT 25 units; bilirubin (total) 0.12 mgm; thymolturbidity 0.6 units; cephalin flocculation 2+; prothrombin 59.5%; BUN 18; serum amylase 151 somogyi units. There was 1-3+ proteinuria with a positive test for Bence-Jones protein.[3] Hospital Course: Complete barium study of the intestinal tract was compared with those previously taken at another hospital and no lesion could be demonstrated. Serum protein electrophoresis showed a tall homogeneous peak in the gamma globulin region[4] and cryoglobulins were demonstrable. There were no bone lesions seen

on x-ray of the skull and pelvis. Free acid was present on gastric analysis.

Despite transfusion of over 7000 cc. of blood, bleeding continued. Abdominal exploration on June 5, 1961 revealed a mass which involved the ileum and there were large mesenteric lymph nodes and a large retroperitoneal mass. The ileal mass was resected and an end to end anastomosis performed. Frozen section of the ileum and nodes was reported as lymphosarcoma. His postoperative course was complicated by a wound dehiscence, atelectasis, pneumonia, and terminally by E. coli septicemia with death occurring on the twentieth postoperative day.

Discussion

In a series of 1269 cases of lymphosarcoma 4.6 per cent presented with gastrointestinal complaints as the initial manifestation.[5] Eleven per cent of this group eventually developed clinical signs or symptoms referable to the intestines and 53.6 per cent had gastrointestinal involvement at autopsy. Faulkner[6] reported several cases of lymphosarcoma with massive gastrointestinal hemorrhage and noted that the most common sites of involvement were the stomach, small intestine (especially the ileum), colon and esophagus in that order of frequency. Radiologically they were indistinguishable from other lesions. In a review of extra-medullary plasmacytomas of the gastrointestinal tract, Sharma *et al*[7] emphasized the infrequent occurrence of such lesions and a propensity for small bowel involvement.

Lymphosarcoma accompanied by dysproteinemia and/or dysproteinuria has been described previously.[9,8,10] Azar, Osserman *et al*[9] suggest that intermediate forms exist and overlapping occurs in the spectrum of clinical and biochemical patterns extending from plasma cell myeloma to the malignant lymphomas and primary macroglobulinemias. Certainly similar serum protein electrophoretic patterns may be seen in each. Bence-Jones protein may also occur in either, although less commonly reported in the latter two conditions.[2,11] Snapper[12] emphatically states that the presence of Bence-Jones protein proves the diagnosis of multiple myeloma and recalls no exception to this when the test is performed as he describes it.

The possibility that macroglobulins were present in this patient's serum remains unknown since an ultracentrifugal analysis was not done. The Sia test was negative. Cryoglobulins may occur in these and other conditions although they are more often found in myeloma and macroglobulinemia.[2]

Abnormal globulins may interfere with blood coagulation in several ways such as protein complexing with one or more clotting factors (fibrinogen, factors V and VII, and prothrombin) and by a demonstrable increase in fibrinolytic activity.[2] Thus it is uncertain how much of a role the disturbance of the clotting mechanism played in the continuing hemorrhage.

Summary

A case of lymphosarcoma manifested by severe gastrointestinal bleeding, dysproteinemia and dysproteinuria is presented. The lymphomas and diseases associated with the elaboration of abnormal proteins are uncommon causes of profound bowel hemorrhage. When the cause of such bleeding is obscure it would seem advisable to perform appropriate studies of serum and urinary proteins. If the bleeding seems localized, surgical intervention must be strongly considered; however if it is diffuse and involving several organ systems simultaneously medical therapy should be attempted.

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Carcinoma of the Cervix—Diagnosis and Treatment

Harold A. Kaminetzky, M.D., *Chicago*

There has been no major advance in the treatment of cervical cancer during the past 10-15 years. However, knowledge and technics to prevent death from this disease are available if invoked early. What is needed is maximum use of the diagnostic tests that can uncover the lesion in its preinvasive and easily curable form. Two factors are of primary importance in early diagnosis. First, the physician must recognize that he cannot detect preinvasive cervical cancer by physical examination alone. Therefore, he must be willing to employ the screening tests as a matter of routine even when there is no reason for clinical suspicion. Second, the patient must be willing to submit to periodic examination.

We demonstrated that the physician cannot determine, in many cases, that there is carcinoma-in-situ by physical examination alone. Among 83 records of patients with carcinoma-in-situ, the first examiner rarely indicated he was suspicious that the woman had cervical anaplasia. This, despite the fact that 61 of these patients had obvious visual or palpable cervical disease as indicated in Table I. The physician simply attributed the symptoms and findings to benign cervical discases. Without further efforts at diagnosis, many of these patients might have received non-specific treatment. At least some of them might ultimately have developed invasive cancer.

Two methods for detecting early cervical cancer are the cytologic smear and the cervical punch biopsy. Cervical punch biopsy has been a standard gynecologic technic for many years. However, our abliity to find carcinoma-in-situ has been given a tremendous boost by the development of the cytologic method by Papanicoloaou. Because the cytologic smear is easily prepared and causes no discomfort, some physicians have discontinued the use of cervical biopsies almost completely. If no cells suspicious for malignancy are found in the smear, they assume that any lesion they see on the cervix is benign. This can be a tragic assumption because the patient and physician are falsely reassured and the patient may not be seen again for years. If carcinoma-in-situ is present and missed, the golden opportunity probably will have been lost. The patient may next appear with an invasive and possibly incurable cancer.

TABLE I

Condition	No. of Patients
Cervical Disease	61
Infection and erosion	57
Hypertrophy	10
"Hard"	10
Vaginal bleeding	36
Intermenstrual	20
Menstrual aberration	18
Postmenopausal	10
"Contact"	8
Vaginal discharge	15

To determine the efficiency of the eytologic method as a detector of carcinoma-in-situ, we reviewed again the records of our patients with proved cases of the disease. All patients admitted for care in our department have routine smears at the first visit, and biopsies are often made then or subsequently. Therefore, short-

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comings of the cytologic method can be assessed. Five patients whose punch biopsies showed carcinoma-in-situ had no suspicious cells in the original screening smears. Thus, the cytologic failure rate is 6 per cent for this series.

An additional study of interest in this regard is a review of our cytologic failures among 187 women with invasive cervical cancer. Of this number, the smears of 12 patients had no cells suspicious of malignancy. This is also 6 per cent of the group. Others report similar and even higher failure rates. Thus, a single screening smear *must* not be considered infallible; there is no perfect biologic test. The principle that emerges is as follows: patients without symptoms or findings should have routine screening smears made at least once a year. However, patients who have abnormal appearing cervices should have four quadrant punch biopsies in addition to the smear. This adds an important additional dimension to diagnosis, and is done easily in any physician's office.

Also of interest in our study of patients with carcinoma-in-situ was the fact that 12 were pregnant or puerperal at the time the diagnosis was made. It is sometimes said that pregnancy can induce changes in the squamous epithelium similar to carcinoma-in-situ. There is no basic evidence to support this contention. About one-tenth of one per cent of our pregnant women had carcinoma-in-situ. Any lesion causually related to pregnancy must certainly appear more often than this. It is far more likely that the lesion actually antedates pregnancy and is discovered because the patient is examined for the first time since its development. This raises an important matter related to the goal of early detection. Pregnancy is an ideal time to introduce women to the advantages of cytologic screening for cervical cancer and selling the idea of an annual recheck. The concomitant pelvic examination may serve also to detect ovarian cancers while they are still curable.

When carcinoma-in-situ is found in punch biopsies of the cervix, or cells suspicious for malignancy are found in smears, the next step should be a cone biopsy of the cervix. This includes removal of the area of junction of the squamous and columnar epithelium and the adjacent centimeter of the endocervix. The squamo-columnar junction is the area in which most cancers of the cervix begin. Sufficient representative blocks (about a dozen) are made for histologic study to rule out the presence of invasive cancer. The treatment for invasive cancer is of course far different from that required for carcinoma-in-situ. In fact, the use of the relatively simple methods for dealing with in-situ cancer for patients with invasive cancer will almost guarantee the latter against a cure. This is a matter of fundamental importance.

Treatment

The treatment of carcinoma-in-situ depends on the patient's age and past childbirth experience. For women wanting more children the cervical cone biopsy done to rule out coexistent invasive cancer may be sufficient for it may have removed all of the abnormal epithelium. If this has been achieved, then repeated smears made thereafter should be free of abnormal cells. If this is the case the patient should be encouraged to have her family without delay and a program of regular follow-up smears is essential. On the other hand, patients with sufficient family are best treated by total hysterectomy, vaginal or abdominal. There is no reason to remove the ovaries and tubes at the time of hysterectomy. If carcinom-in-situ is detected during pregnancy by punch biopsy, a cone biopsy must be done as in the nonpregnant. If there is no invasive cancer the patient may carry to term and give birth vaginally. The cervical lesion is usually dealt with peurperally in accordance with the age and parity of the patient.

The treatment of invasive cervical cancer is basically radiologic although in some centers early lesions are treated by radical surgery. In Stage I carcinoma where the lesion is confined to the cervix, both radiation and surgery are applicable and equally good results can be expected provided both methods are applied expertly. Not all women are candidates for radical surgery. In general, with Stage I cancers, we prefer to operate on patients who are young, thin and of low parity. Obese women or women over 50 are seldom good candidates for radical surgery and radiation is the preferred and usual treatment. Women with Stage II and III cervical cancers are treated radiologically. Stage

IV cervical cancer may be treated in some patients only to palliate specific symptoms. Adequate treatment of cancer involves considerable patient discomfort no matter which modality is employed. This is ignored if there is hope for cure or at least arrest of the disease process. However, where there is no such hope it is relatively pointless to add to the suffering of patients by futile treatment that may be harder to bear than the terminal phase of the disease itself.

The treatment of invasive cervical cancer in pregnancy in general follows the plan for the non-pregnant patient. Ideal treatment consists of external irradiation after removal of the fetus by abdominal hysterotomy. After uterine involution radium may be applied. If removal of the living fetus is unacceptable, external radiation is started first. Although the fetus will succumb, the radiation treatment is not considered a direct attack upon it. After fetal death the uterus will empty itself and following shrinkage, radium can be applied. The one disadvantage of this method is that the cancerous cervix must dilate to permit expulsion of the fetus. This might result in dissemination of the cancer.

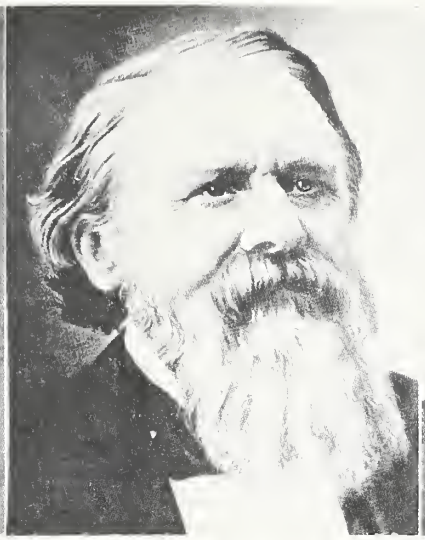
Because cervical cancer is often treated by radiation, it is useful to mention briefly some of the principles that lead to success. The uterus is an ideal radium container. In most cases, a cancericidal dose can be delivered to the cervix proper. The thickness of the uterine wall helps prevent overdosage of the bladder, rectum and small bowel. The treatment problem is to provide a cancericidal dose of radiation to regional lymph nodes especially at the pelvic wall. To increase the dose to these areas, external irradiation is added. It is difficult to provide a sufficient dose to the entire pelvis without causing severe radiation damage. The most sensitive tissues are the skin and the mucosa of the bowel.

From what has already been said it is clear why the treatment of invasive cervical cancer by simple total hysterectomy is hopelessly inadequate and may limit the patient's chance for cure by subsequent radiotherapy. When the uterus is removed it obviously cannot be used to hold radium. As a matter of fact, after hysterectomy, the bladder is in close relationship to the upper vagina. Small bowel may also become adherent in this area. Thus, the application of radium to the upper vagina for a period of time to provide an adequate dose to residual tumor will probably cause irreversible damage to bowel and bladder.

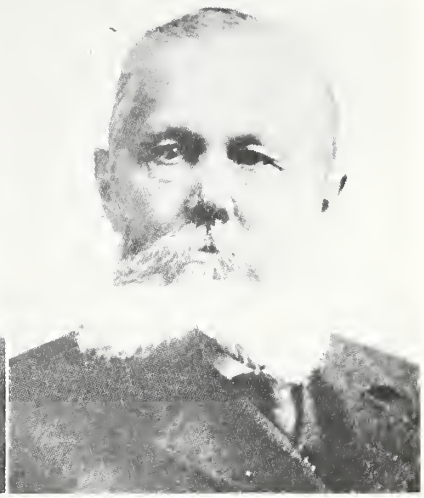
Finally, there is the problem of treatment of recurrent cervical cancer. Usually, if maximum radiation has been applied, little gain can be expected from more. There is danger of exceeding tolerances of bowel, skin and bladder. About all that can be offered is widespread removal of the pelvic tissues, the so-called exenteration operation. This involves removal of the uterus and parametria plus bladder and/or rectum. This kind of surgery has high mortality and morbidity associated with it and only about 5-10 per cent of patients are cured. The difficulties involved, the major complications during and after operation, the enormous cost involved, and the small chance of success makes one wonder whether any patient should be subjected to it. In the final analysis, it is a matter of philosophy, and by all means the patient's wishes should be considered. She and her family must be informed fully about what is involved.



Edward Mead
1819-1883



John Evans
1814-1897



Walter Hay
1830-1893

The History of Neurology in Chicago

ROLAND P. MACKAY, M.D., *Chicago*

THE HISTORY of neurology in Chicago is the history of the neurologists who have labored in this city, and begins in the middle of the nineteenth century. But any appreciation of their labors requires a view of the society in which they lived and which set physical and ideological bounds upon their activities. If we would see these men in the round, therefore, we must set them in the background of their lives. To this end, we shall examine first the pioneer setting, general and medical, in which our neurologic forebears lived, and then follow by quarter-centuries the principal changes in this city that greeted their successors, sketching as briefly as we may the lives and characters of the men who adorned each period. As the boundary of our story, we shall exclude all living neurologists (lest candor shrink from unwitting offense) and all neurologic surgeons (as lying beyond our legitimate purview).

This is the first installment of an informative history of neurology not only in Chicago as the title would indicate but throughout the state and the nation. In a delightful and interesting style, Dr. Mackay paints a picture of the growth of neurology as seen against the times in which it was practiced—a story of a city and specialty growing together.

Read before the International College of Surgeons, Chicago, Illinois, March 19, 1963. Excerpts of this article appeared in the Journal of the International College of Surgeons, August, 1963 under the same title.

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*For much of the material here presented on the general history of Chicago, I am deeply indebted to Emmett Dedmon's *Fabulous Chicago*.[1]

The Pioneer Setting, 1850

This community, when it was incorporated in 1833, was "essentially an Indian town",* and devoted chiefly to trade with the Indians. It boasted of only two women of marriageable age, and was soon concerned to push the Indi-

ans west of the Mississippi River. It lay in a marshy swamp which was not conquered for over 25 years, and which dominated the pioneer setting.

It was indeed a frontier community, and Illinois a frontier state. Paul M. Angle's sketch of "The Hardy Pioneer"[2] paints a vivid picture of nature in the raw and a primitive populace too tough to surrender, or to care. From the swamp came mosquitoes in black clouds, and filth was the normal state in country inns and rural homes. William Faux wrote of Illinois in 1819 that "soap is nowhere to be seen in any of the taverns. . . . Hence dirty hands, heads and faces were everywhere. . . . The face is seldom shaved or washed, or the linen changed except on washing days." Lice and bed bugs thrived, houseflies shared one's supper and, if fanned, were driven into the molasses, while cockroaches raced across the table in spite of bitter blows with knife and spoon. Tobacco was chewed almost universally, the juice being spat "in the direction of receptacles if there were any; if not, on the floors or streets." Whiskey was a universal elixir; before dinner it stimulated the appetite; after eating it aided digestion. Clean drinking water was not often available or desired; on river boats table water was secured by lowering a pail over the side.

In the cities things were not much better. In Cincinnati, in 1827, an ordinance prohibited the deposit of mud, dung or filth in streets or alleys, or the leaving of dead animals or excrement from privies in the built-up section of the city, and Chicago's first ordinance, in 1833, forbade much the same. Dr. Daniel Drake wrote in 1850 that "an overwhelming majority of our population seldom bathe at all." But, as Angle observes, "not all pioneers were dirty, intemperate gluttons, or so ignorant,—but the generality were. Further, improvement occurred steadily around 1850."

In 1850 Chicago had witnessed the gold rush of 1849 which indeed continued. Hundreds of Americans poured through Chicago in wagons on their way to fortune or famine. Dedmon[1] describes the great camp south of Fort Dearborn, its campfires reddening the sky at night, while the town crier with lamp and bell dutifully searched for lost children. Travelers to the west were described by one writer as consisting of all sorts of men including horse thieves, land speculators and "other birds of passage—mostly vultures." About 1850 the Cook County Commissioners set ceiling prices to protect the travelers stopping at taverns—25c for half a pint of wine, rum or brandy, 12½c for half a pint of whiskey or a night's lodging, and 25c for breakfast or supper!

Chicago's streets were abominably paved, or more often not at all. Sidewalks, high above the streets, were composed of rough boards, often out of repair and dangerous for the pedestrian. Mud was the universal plague in bad weather, and rickety boards served as unsure bridges along which the populace threaded its perilous way. In winter one could skate for miles over the frozen marsh. In summer the drabness of the streets was relieved by the green trees, of which there was an abundance, even in the business districts. And around all was the luxuriant, flowered prairie, white and blue in spring and golden yellow in summer.

The Medical Scene, 1850

The medical scene in Chicago in 1850 is of considerable interest.[3] Rush Medical College had been founded in 1843 by Daniel Brainard who gave the first lectures in anatomy, physiology and surgery to 22 students in his own office at Clark and Randolph, with a shed in the back for dissection. At the same time the Illinois College, with its medical department, was founded at Jacksonville, Illinois, but the medical department closed its doors after only 5 years of existence. At Rush a new building was erected in 1844 at the southeast corner of Indiana (now Grand) Avenue and Dearborn Street which served unaltered for 11 years. Rush Medical College was located at this spot, in a building frequently altered and enlarged, until the great fire of 1871, and in the "college under the sidewalk," until its removal to new quarters at Harrison and Wood Streets in 1876. In 1849, the remarkable Nathan Smith Davis came from New York to become Professor of Physiology and Pathology at Rush—destined to leave the mark of his stubborn personality on Chicago for many years. In 1850 the population of Chicago had already reached 28,000, and the number of students at Rush, 104. In this year also,

the United States Marine Hospital on the east side of Michigan Avenue near River Street neared completion while the Illinois General Hospital of the Lakes had been chartered, to open in the old Lake House at North Water and Rush Streets, and, in the next year, to pass under the care of the Catholic Sisters of Mercy, as Mercy Hospital. It is in this Chicago and this Illinois, then, in the year 1850, that we begin our survey of the history of neurology.

The Neurologic Scene, 1850

It is well to remember that in 1850 clinical neurology had scarcely been born anywhere in the world. True, Claude Bernard was in his prime at 47 years of age but Charcot at 25 still had most of his work ahead of him. The great J. Hughlings Jackson, the father of modern neurology, was only 15, Argyll Robertson 13, Wilhelm Erb 10, and Dejerine and Pavlov were but mewling infants of 1. Among Americans, S. Weir Mitchell was 21, but not yet on his scientific way, while Huntington was born in this very year. Still to be born were Alzheimer, Bielschowsky, Nissl, Pierre Marie, Babinski. In Illinois there were as yet no simon-pure neurologists. As Bassoe has pointed out,[4] the first medical approach toward a neurologic specialty was *via* psychiatry. The care of the insane was imperative, and the physicians developed the truly revolutionary idea that this was a problem for them and not for the police. As a result, they sought to provide medical and hospital care for mad people, instead of brutal imprisonment. Thus was born the scientific approach to the most subtle and complex of all disorders of the nervous system—mental derangement. In this movement, two men worthy of our attention had already appeared on the Illinois scene before 1850. As we shall see, they were not rigid specialists, but in their astonishing versatility they ranged the whole vast field of medicine and surgery.

Edward Mead, born in Leeds, England in 1819, came to the United States at the age of 12, and was apprenticed in medicine at 19 to Dr. Robert Thompson of Columbus, Ohio, finally graduating in 1841 at the Medical College of Ohio. Thompson was keenly interested in the insane, and Mead was a student when Ohio established its first Lunatic Asylum. After graduation he traveled to Paris, London and Dublin for further studies, returning to the United States, spending a time in Cincinnati and then moving to the vicinity of St. Charles, Illinois, where, in 1842, he set up his general practice. He drove his horse through mud and flood, wolves howling after him on his rural calls. He taught in the new Franklin Medical School in St. Charles. He also became Professor of Materia Medica and Therapeutics at the Illinois College Medical Department, in Jacksonville. In his travels about the state Mead was struck by the deplorable treatment of the insane, who were manacled and locked in cabins no better than pens, unheated, and with dirt floors. He worked ardently for an Illinois State Hospital for the Insane, wrote 700 personal letters to stir up public interest, and cooperated with others in Jacksonville who were pushing the project. This hospital was finally opened in 1851. Mead did much to promote better medical education in this state. In 1847 he opened, on Kinzie Street, the first private asylum for nervous patients in Chicago, and later moved it to a point 2 miles north of the City. This "Retreat" burned in 1851, whereupon he returned to Cincinnati, to become in the versatility of his day, Professor of Obstetrics and Gynecology in the Cincinnati College of Medicine and Surgery. In 1853 he founded the American Psychological Journal which, however, lived for only one volume. He opened another "Retreat" in Cincinnati in 1853 and still another in Winchester, Massachusetts, in 1872, and a final one in Roxbury in 1873. He was small in stature, stocky of build, and spoke German and knew French. He was a ready speaker and writer. He died in a shipwreck at sea while on vacation in 1883.[5]

The second great figure in our survey of 1850 is the illustrious *John Evans,* truly a giant in the land. Born in Waynesville, Ohio, of Welsh-Quaker descent in 1814, he graduated at Lynn Medical College, Cincinnati in 1838. Upon graduation, he left home on a pony, with ten dollars from his father, and went west to Indiana, where he started the practice of medicine at Attica, remaining there from 1839 to 1845. During that time, he became a fast friend of Abraham Lincoln. Largely through his efforts

he secured the establishment of the first Indiana State Hospital for the Insane,[6] and became its first superintendent in 1844. This was his great contribution to psychiatry. Also, while in Attica he became lecturer in obstetrics in Rush Medical College, commuting 100 miles for 3 years until he moved to Chicago in 1848. Here, this remarkable man became editor of the Northwestern Medical and Surgical Journal, and with Nathan S. Davis was co-founder of the American Medical Association, Illinois State Medical Society, and the Chicago Medical Society, all in 1850. He was a member of the Chicago City Council and was instrumental in founding the first high school in Chicago. His writings were not primarily neurologic or psychiatric; in one paper he presented his observations on insanity and its treatment in private practice.[7] Others were concerned with the spread and communicable nature of Asiatic cholera,[8] a memorial to Congress asking for quarantine regulations to prevent the spread of cholera,[9] and a description of the obstetrical extractor.[10]

He was a vigorous member of the group that founded Northwestern University, to which he is said to have contributed $180,000, and to have secured exemption of the new university from state taxes. He remained the first president of the University's Board of Trustees until his death, 42 years later. The town of Evanston is named for him. He also organized the Illinois General Hospital of the Lakes, later Mercy Hospital. He raised funds to build the Chicago-Fort Wayne Railroad, destined to become part of the Pennsylvania System. During all this time he was Professor of Obstetrics at Rush.

John Evans was a member of the Republican Party Convention at which Lincoln, his friend, was nominated for the presidency. After his election, Lincoln appointed him the Territorial Governor of Colorado. There he continued his prodigious labors, building the Cheyenne to Denver Railroad, opening mines, installing street cars in Denver and founding Denver University, to which he gave $150,000 and land. Mount Evans was named for him by legislative action. He died in 1897. Though his efforts on behalf of neuropsychiatry were only a minor part of his activities they were nevertheless important, and we notice him for them, and for his multilateral genius—one of the great Americans of the nineteenth century.

The Chicago Setting, 1850-75

During the fateful quarter-century, 1850-1875, Chicago burst its bounds, as its population, swollen not only by births but also by the flood of westward migration, leaped from 28,000 to 400,000. Private enterprise ran rampant in the wild freedom of an unparalleled expanding economy. Fantastic wealth accumulated; the poor could always work harder or move on. Mansions patterned after Rhenish castles or English palaces vied with each other in ostentatious magnificence and splendor. The Yankee aggressiveness responsible for this lush society produced also the prodigious drunkenness, gambling, civic corruption and graft of those years. Prostitution, described by the famous Madam Carrie Watson as "the natural result of poverty on the part of the woman and passion on the part of the man," was gaudy, efficiently organized and openly advertised in special sporting house directories listing the bordellos in alphabetical order and classifying the girls by price. Thus, the raw town grew into a brawling and bawdy city "on the make."[1] On the other hand, many became concerned for cultural progress and better morals, and a group of earnest young Methodists planned and, in 1851, chartered Northwestern University north of the city in "a community of desirable citizens." This great institution opened in 1855 with its first class of 10 students, and the "community for desirable citizens," was named Evanston for our John Evans. On the south side, an original Chicago University was founded in 1856, on 10 acres donated by Stephen A. Douglas, but was destined to close in 1886 in a financial panic.

The Medical Scene, 1850-75

Rush Medical College was split in 1859 by a controversy between its stubborn secretary, Nathan S. Davis, who urged the establishment of graded courses, and its equally stubborn president, Daniel Brainard, who opposed the idea.[11] Davis took others with him and they joined a newly organized medical department

of Lind University. There were 33 students in the first session of this new medieal school, whieh had set up a graded eourse and exeeptionally high standards of admission and aeademic work. However, in 1861 Lind University, in financial straits, asked release from their contract, and the medieal school thereupon assumed independent existence as the Chicago Medical College whieh, 8 years later, in 1869, became the medical school of Northwestern University. In this schism Rush not only lost important and progressive figures from their faeulty, but lost Mercy Hospital as well, and so went in 1859 to the newly formed City Hospital for its clinical teaching. The City Hospital was transmuted in 1866 into the Cook County Hospital which has served so importantly in the medical history of this city. On October 19, 1866, Dr. Daniel Brainard, founder of Rush Medical College and its president for 23 years, died of cholera—a day on which 100 other persons in Chieago died in an epidemic of that disease. In 1868 the Bennett College of Eclectic Medicine and Surgery was founded, a college which years later was incorporated with sundry other schools into Loyola University as its college of medicine. In 1870 Dr. Mary Harris Thompson, so far as I know the first woman physician in Chicago, who had been refused admission to Rush, but who then became the only woman to receive a medical degree from the Chicago Medical College before its union with Northwestern, organized the Woman's Hospital Medical College in the Chicago Hospital for Women and Children which she had set up in 1865 in an old building at 1 North Clark Street. Eventually this college was also absorbed into Northwestern University Medical School.

In the catastrophic fire of October 1871 the medical toll was great. Rush lost all its buildings and their entire contents, but within a few days resumed classes in a small amphitheatre at the top of the County Hospital while the Chicago Medieal College offered Rush a room for dissection. The trustees of Rush then built a temporary "college under the sidewalk" of rude brick and a tar roof, unplastered, which served for 4 years. The Woman's Medical College was also completely destroyed, but on the very next day, October 10, lectures were taken up at 400 West Adams Street.

The Neurologic Scene, 1850-75

Between 1850 and 1875 neurology was born in Chicago. But its votaries embraced within their field both neurology and psyehiatry in a view at once logical and practical; as we shall see, they still considered the whole of medicine as their eoncern. Versatility was the hallmark of their genius; a narrower specialization was yet to come. In this quarter-century four remarkable men appeared who contributed greatly to the neurologie tradition of this city, and were of first importanee on the national neurologic scene. Their life stories afford us a glimpse of the nobility of our scientifie forebears.

Walter Hay, one of the most effective members of the medical profession in Chicago, was born in Georgetown, D.C., June 13, 1830, educated in private schools and a Jesuit eollege in that town and graduated from Columbian Medieal College there in 1853. Four years later he came to Chicago and set up a practice in neuropsychiatry that lasted for 36 years. He joined the faculty of Rush Medical College and was appointed physician in charge of St. James Episcopal Hospital. In 1864 he was one of the founders of St. Luke's Hospital and its first physician. He helped organize the Chicago Department of Health in 1867, the year in which he became associated with Dr. J. Adams Allen in editing the Chicago Medical Journal. In 1871 he was secretary of the committee that disbursed the Chicago medical relief fund contributed from far and near for victims of the great fire. Also, in 1871, he organized the Department of Mental and Nervous Diseases in Rush and 2 years later set up the same department in St. Joseph's Hospital. With James S. Jewell and Henry M. Bannister, also of Chicago, he met in New York in 1875 with other national leaders in neurology to organize the American Neurological Association. In 1882 he left Rush for the Northwestern University School of Medicine, to beeome Professor of Materia Medica and Therapeutics. He was chairman of a speeial committee of the Illinois State Medical Society, appointed in 1883 to ask the

State legislature to modify the laws governing the commitment of the insane. The committee recommended that judges of the district courts appoint two physicians in each county to constitute, with the county judge, a County Board of Commissioners of Insanity. I have not been able to learn the fate of this recommendation. In 1884, upon the retirement of the great James S. Jewell, he became the second Professor of Nervous and Mental Diseases at Northwestern University School of Medicine with Medical Jurisprudence added to his tutorial responsibilities. After years of teaching and private practice in neuropsychiatry he retired in 1890, at the age of 60, to a farm near Annapolis, Maryland, where he died 3 years later.

James Stewart Jewell was not only the most widely influential and scholarly pioneer of neurology in Illinois, but was as well a fascinating and complex personality, compounded of a Puritan hunger for righteousness, a personal passion for knowledge and a yearning for perfection and achievement. To follow his career is to gain a nostalgic vision of the inflexible virtues of our fathers.[12] His parents, of Scotch-Irish descent, came by wagon, detouring washouts for 700 miles, from Franklin County in far-southern Illinois to build a log house 20 miles from Galena, where James, the first of eight, was born on September 8, 1837. The family lived in extreme poverty but cherished a few treasured books, including the *Bible*, Fox's *Book of Martyrs* and a *History of the Jews*. Young James proved to be a bright lad who knew his letters at 2, read at 4, and started to school at 6. His mother was described as being of indomitable spirit, strength of character, deep religious conviction and love of learning. She read to her son in his early years as they rested from working in the fields. When he was 14 the family moved again to southern Illinois, where he returned to school with gladness, but his training was short and interrupted by the need to help support the family. Strange, heavy books were added to this farmer's little home library—on natural history, geology, anthropology, classical poetry and history. With the help of these and his mother's spirit, he developed a love for reading and reciting what he had read, such as the history of the wars between the Greeks and the Persians, and the intriguing story of geology.



James Stewart Jewell
1837-1887

At 18 he began the study of medicine under the preceptorship of Dr. S. M. Mitchell of Corinth, Illinois. Four years later, in 1858, he came to Chicago to continue his medical education at Rush Medical College and later at the medical department of Lind University, where he graduated with the degree of M.D. in 1860, aged 23. Even before graduation he began teaching anatomy and was utility teacher of any subject. But his interests were wider than medicine, and one of his first expenditures in Chicago was ten dollars for membership in the Chicago Academy of Sciences. After graduation he acquired a good reading knowledge of French, German and Italian, and a wide knowledge of Latin and Greek. His interests in geology led to his writing about caves in southern Illinois. When Darwin published his *Origin of Species* in 1859, Jewell sided with the anti-evolutionists, and wrote a book, never published, to combat evolution. In 1862 he was appointed Professor of Anatomy at the Chicago Medical College, a position he held until 1869 when that college became the medical school of Northwestern University. He was admired as "one of the most brilliant and fascinating lecturers of his time." Many called him the best teacher they ever had. In teaching anatomy he used the comparative method, with the nervous system as a framework for his descriptions.

He was described as "tall and angular, with a large head, adorned with a shock of brindle hair, prominent gray eyes and spindling legs," a man of "ungainly appearance" but "rare brilliancy." The entry in his diary for January 1, 1860, reads as follows: "This, the first day of another and eventful year, I am resolved, God being my helper, to make it the best and most profitable year of my life. How many hopes and how many fears shall I have and suffer this year? How much do that is worth the doing? How much do to make my life sublime? O God on high, give me, O give me the strength to do, and will and opportunity!" Again his diary records: "I lectured today on the brain, and purchased Allison's *History of Europe* and also the *Commentaries* of Blackstone. I am eager for good books. (There was no television then!) I am looking at Hebrew now, occasionally, and I earnestly desire to be a classical scholar. May my desire be filled." Since it was 1860, he added, "I am afraid for my country!" Finally, his diary in January 1863 reads: "Spent the usual time in the dissecting rooms. Must give a private course on various topics. . . . Read the Emancipation Proclamation. Great rejoicing here over it among the people. Bells rung and guns fired. Must buy some hard coal." He served during a portion of the Civil War as Contract Surgeon under General Sherman. After the war he continued his academic work, and wrote a book on cerebrospinal meningitis published in 1866 (Chicago).

In 1869 Jewell resigned as Professor of Anatomy of Chicago Medical College at about the time when that institution became the medical school of Northwestern University. His religious activities had included teaching a Bible class said to have been the largest in Evanston (apparently, indeed, a "community of desirable citizens"), and his purpose in resigning was to travel in Italy, Palestine and Egypt to enlarge his knowledge of ancient and Biblical history to improve his teaching. He spent 2 years there in widespread investigations, including intensive studies of cuneiform inscriptions and Egyptian hieroglyphics. (The Rosetta stone had been deciphered at last!) He wrote three manuscript volumes on these travels, now to be found, unpublished, in the Crerar Library in Chicago. Upon his return he lectured on his observations, illustrating the talks with his own drawings.

Back in Chicago in 1871, the year of the great fire, he restricted his practice to neurology and psychiatry, with principal emphasis upon neurology. In 1872 he became Professor of Nervous and Mental Diseases at Northwestern University and in 1874 he and Henry M. Bannister founded and jointly edited the Chicago Journal of Nervous and Mental Diseases. Two years later the word Chicago was dropped from the title of this journal which has continued uninterruptedly to this day as the Journal of Nervous and Mental Diseases. Jewell's editorial skills were exemplary and successful. He wrote the first article published in his journal, entitled "The Pathology of the Vasomotor Nervous System" and contributed an editorial on the deplorable state of medical education, pointing out that the whole course consisted of only two sessions of four or six months . . . "to foster the miserable superficiality which has been and is yet so common . . . and hence to crowd to a still greater plethora the profession with incompetent members . . ." In the second volume he contributed an editorial castigating that day's care of the insane, who were "kept in stone cells six by nine feet (in size), often without a window and without any means of heating in winter." In Will County near Joliet there was "a low, dark, miserable room, twelve by fourteen feet, called the 'calaboose', partitioned off with board slats, hardly fit for a beast, in which the insane of both sexes are huddled together at night like hogs in a sty. During the day the insane males are removed to and confined in a corn-crib nearby." In the same issue there is a plea for teaching psychiatry to medical students!

In breadth of vision and scope of activity, he attained outstanding national stature. He was one of the seven signers of the original invitation to neurologists over the nation to meet in New York to form the American Neurological Association on June 2, 1875, and he served that association as its president for its first 4 years. He submitted three papers for the first program of the association, entitled (1) "The Structure and Functions of the Ganglia on the Posterior Roots of the Spinal Nerves"; (2) "A Case of Insanity Caused by Wound of

the Brachial Plexus Nerves"; and (3) "A Case of Diabetes Insipidus Caused by Disease of the Meatus Auditorius Externus." Thereafter he contributed many other papers on neurology to his own Journal of Nervous and Mental Diseases and to others.

Probably no man in America had more knowledge of the literature of neurology and psychiatry than did Dr. Jewell. He took great pride in his library, which reached 3000 volumes before his death, and was then transferred to the Newberry and eventually to the Crerar Library. His health declined after 1880, and in 1884 he retired to Florida where he studied the cerebral anatomy of birds. After his return in 1886 he founded a new journal, The Neurological Review, but his poor health forced him to discontinue its publication after only one volume had appeared. He died of pulmonary tuberculosis in 1887, only 50 years of age!

(To be Continued)

The View Box

—diagnosis and discussion

(continued from page 43)

Diagnosis: Sickle Cell SS Disease

Skeletal changes:

a) Changes due to thrombosis of vessels.

These changes may be in the short bones of the hands and feet in very young patients (1-2 years of age). In the long bones, the radiological picture lags behind the clinical picture by about 2-3 weeks. The necrotic bone is removed by osteoclastic resorption. The infarct may be in the medulla of bone or may be in the region of the articular cortex, accounting for the various changes of the hips and femurs and of the pelvis in our case.



Case 2 Fig. 4

b) Changes due to hyperplastic response of erythroblastic elements due to long standing hemolytic anemia.

This accounts for the appearance of the spine with biconcave vertebrae (Case II, Fig. 4). The skull changes take the form of widening of the diploic spaces and thinning of the outer tables, which accounts for the sun-burst appearance in the posterior parietal bones of Case I.

Salmonella osteomyelitis is a complicating disease.

The severe anemia accounts for the cardiac enlargement. Pneumonitis or pulmonary infarcts will cause the pulmonary changes. (Fig. 1).

Fig. 4 also illustrates additional changes which occur: gall stones usually pigmented in type and diffuse calcification of the spleen.

Illinois Medical Corporation Act

Frank M. Pfeifer, *Springfield*

The medical profession may see fit to change the manner in which it has carried on its practice, for now the members may operate as a corporation as well as a partnership or as an individual. The prohibition against the practice of medicine by a corporation in the State of Illinois, as exemplified in the case of The People v. United Medical Service, 362 Ill. 442, which was decided by the Supreme Court of Illinois on February 14, 1936, has been eliminated by the passage of House Bills No. 1207, 1208 and 1209 (¶631 through 647, Chapter 32 Illinois Revised Statutes 1963). By this new law known as "The Medical Corporation Act," which was approved by Governor Kerner on August 30, 1963, the legislature of Illinois removed the prohibition against incorporation so that the individual physician, or a group of physicians may wish to investigate the advantages and disadvantages of incorporation.

One or more duly licensed physicians may now form a "medical" corporation according to the terms of "The Business Corporation Act," which is the act generally thought of as that pertaining to corporations for profit, but there are certain provisions applying particularly to the physicians so incorporating which have no relation to the provisions pertaining to corporations in general. However, "The Business Corporation Act" does govern the new "medical" corporation except as this may be limited or enlarged by "The Medical Corporation Act."

Obviously, the interests of the public require safeguards against abuses so that no employee of such a "medical" corporation may give medical or surgical treatment, consultation or advice, unless such employee is licensed pursuant to the Medical Practice Act itself.

The act provides that the corporation may bear the last name of one or more persons currently or formerly associated with it or may use a name which does not include the surname of anyone connected with it, but in the last instance the names of the shareholders must be recorded in the county wherein its principal office is located. Particular provisions do provide that certain words must be employed at the end of the corporate name such as "chartered," or "limited" or "Service Corporation" or abbreviations of the last two styles.

Again, the new Act has provisions differing from those of the "general" act in requiring that the corporation must obtain a certificate of registration from the Department of Registration and Education, which certificate must be renewed annually and cannot be assigned. The Department has certain duties to perform in investigation before issuance of such certificate and in its investigation must find that each and every incorporator, officer, director and shareholder is licensed under the "Medical Practice Act" and that no disciplinary action is pending before the Department against any of them. After registration the Department may suspend or revoke the certificate under certain circumstances. In such instance as that in which any officer, director, shareholder or employee shall have his license to practice medicine revoked or suspended, the other "members" of the medical corporation must promptly remove or discharge such person or suffer loss of the corporation's certificate and like action must be followed by the "members" of the corporation if any shall

General Legal Counsel
Illinois State Medical Society

conduct himself unethically professionally.

The Act provides that written notice and a public hearing must be had before the Department shall revoke or suspend a certificate of registration and that the reasons for the proposed action must be set forth in such notice. Review of such action by the Department would be had under the provisions of the "Administrative Review Act." Hence, arbitratory action by the Department is safeguarded against by these provisions which make is possible to go before the Circuit Court and the courts of appeal.

The Act again differs from the "general" corporation act in its provisions as to the results that flow from the death of a shareholder. Obviously, since a shareholder must be a duly licensed physician, his widow or children cannot follow in his position and so "The Medical Corporation Act" provides that if the articles of incorporation or by-laws fail to state a price or method of determining a fixed price at which the corporation or its shareholders may purchase the shares of a deceased shareholder "or a shareholder no longer qualified to own shares," the price shall be the book value as of the end of the month immediately preceding the death or disqualification of the shareholder and book value shall be determined in accordance with the regular method of account used by the corporation.

Another particular provision that would have no relationship to the "general" corporation act is that which provides in Section 14 thereof that: "This Act does not alter any law applicable to the relationship between a physician furnishing medical service and a person receiving such service, including liability arising out of such service." The result must be then that while recovery of damages against the corporation itself would be limited in satisfaction thereof to whatever the assets of the corporation would amount to, yet the individual physician would be as much liable as he would be if "The Medical Corporation Act" had not been enacted. The advantage of limiting what can be lost in an unsuccessful business, which is an important advantage in incorporating generally, is not a feature of "The Medical Corporation Act" insofar as it has to do with the individual physician concerned as to his own acts. However, the physician who is a shareholder in the medical corporation may lose his investment in the medical corporation through the act of another employee or shareholder of the corporation, but at least his liability would be limited to his investment in the corporation, rather than the loss that could result if the physicians were operating as a partnership, in which instance the individual physician would be liable for the act of another to the full extent of his own property as well as the assets of the partnership being used to satisfy any debt.

After this resume of the features of the new statute, you may well have in mind some questions as to the why and wherefore of the need of the act itself. Various bills have been before the National Congress in the past dozen years in the effort to secure for self-employed persons the tax advantages previously enjoyed by employees of corporations but which did not exist for the person who "was on his own." The Act commonly known as the Keogh Bill (the Self-Employed Individual Tax Retirement Act of 1962) did change the situation for taxable years beginning in 1963. By this enactment the self-employed can contribute up to 10 per cent of earned income or $2,500, whichever is less, annually into a retirement plan and half of this can be deducted on his income tax return so that the sole proprietor (with no employees) in the 50 per cent bracket might set aside $625 free of income tax into his retirement plan each year. Among the provisions of this Act other features were: retirement plan must cover all full-time employees with three or more years of service; portion contributed on behalf of each employee must be fully vested and non-forfeitable; moneys into plan must be from earned income alone and not from invested income in most instances; certain estate tax exemptions available to employees of corporations would not be available to employees of the self-employed. Naturally, the foregoing is only the barest of outlines of facts under the Keogh Bill and is designed only as a reminder that the self-employed physician as an individual or partner had made certain gains income tax-wise for his retirement with something other than fully taxed dollars.

The employee of the corporation even so en-

joyed greater benefits retirement-wise than the self-employed person and his employees. It is estimated that more than 60,000 qualified pension and deferred profit sharing plans now exist in the U.S. as to corporations and of these some 10,000 new plans were qualified by the Internal Revenue Service in 1962.

Since you now have the right to incorporate, it is possible for the practitioner to enjoy some of these advantages which are briefly summarized: the corporation's contributions to the retirement plan are deductible when made so that you are paying moneys into your retirement plan rather than as income tax; the interest from moneys in the fund is exempt from tax as it accumulates; the employee is not taxed on the corporation's contribution to the fund but when he receives the money is taxed, which in by far the larger number of cases would be when the employee is in a lower bracket as to income tax and would probably be after attaining the age of 65 when double exemptions are available; certain long-term capital gain treatments exist; the primary $5,000 of distribution from the plan's funds, paid at one time, may go to a beneficiary free of income tax; certain death benefits may be excluded from federal estate tax; employees under 30 (or over 60) may be excluded; may require employment from one to five years before an employee can be included; the plan may be limited to employees whose annual salary exceeds $4,800.

It has been mentioned hereinabove that some 10,000 new plans were qualified by the Internal Revenue Service in 1962 and this indicates that, as the benefits of retirement systems and deferred profit-sharing plans become more generally known to the owners of small businesses, there will be an imposing workload placed on the IRS for its approval of the plans so that the persons, who will become entitled to pensions, can be assured that their own plan complies with all legal requirements. Any plan evolved will require expert guidance and vexatious delays will be met before the practitioner finds that his pension plan is enjoying the advantages of his tax-sheltered dollars.

The treatment in this article accorded the subject is basic only, and over-simplified in that it does concern a subject of many ramifications that would require a large amount of planning and detail to put into operation for your best benefit. While not every benefit exists under "The Medical Corporation Act" that exists for the usual corporation under the "general" corporation act, there are benefits for the economic well-being of the medical profession that did not exist previously. The article appears for the one purpose of directing your attention to a new state of affairs that merits your consideration in detail with your attorney and accountant.

Business Backs Medicine On Medicare

On November 21, 1963, James A. Mann, Chairman of the Social Security Committee of the Illinois State Chamber of Commerce, testified against HR-3920, before the House Ways and Means Committee. The below listed quotation of a portion of that testimony indicates how our allies in the business world feel about this issue. The question arises as to whether or not the individual physician who is vitally concerned is asking his friends in the business world to speak out. Hearings on the King-Anderson Bill (HR-3920) will resume for five days beginning January 20 or January 27. The delay in these hearings alters the situation materially. A campaign to vote this measure out of Committee at that time is fully anticipated. Now is the time to ask our friends to speak out in letters to their Congressmen and Senators.

V. P. Siegel, M.D.
Chairman, Legislative Committee

Costs and Taxes

It is indeed surprising and alarming to us that at this time when our government is insisting on a tax reduction to increase purchasing power and spur our economy, serious consideration is being given to legislation that would place an onerous burden of additional taxation on our working population—the producers and purchasers of this nation. Social Security is most certainly a tax program and we know that any government financed medical benefits program is going to cost taxpayers more in taxes and these taxpayers will not be just the "rich and the employer." They will be the working people, those having homes to build, children to educate, income, real estate and sales taxes to pay. Already, many of them are paying more in Social Security taxes than in income taxes.

The costs of the program as suggested in H.R. 3920 are almost impossible to predict and your committee, I know, will give careful consideration to the estimates provided by government and insurance actuaries. However, it is unnecessary to look at future costs to determine that further Social Security tax increases must occur and again it is alarming to note the increases in this tax that have occurred over the years and are already scheduled in the present law. Experience in Social Security indicates that the costs of these government programs will exceed the estimates. To point this out, we need look only to the past six fiscal years ending June 30, 1963 when the program was supposed to be on a "pay-as-you-go" basis.

Year	Tax Payments	Benefit Payments	Deficit
1958	$ 7,267,000,000	$ 7,875,000,000	$ 608,000,000
1959	7,565,000,000	9,049,000,000	1,484,000,000
1960	9,843,000,000	10,270,000,000	427,000,000
1961	11,293,000,000	11,185,000,000	(+108,000,000)
1962	11,455,000,000	12,658,000,000	1,203,000,000
1963	13,328,000,000	13,845,000,000	517,000,000
Total	$60,751,000,000	$64,882,000,000	$4,131,000,000

Again, another deficit in our Social Security program must be recognized—that concerning disability benefits, a program that is not paying its own way. Starting in 1957, this program, too, has expanded. The funds to pay these benefits come from the Social Security tax, presently 3⅝ per cent each on the employer and employee with ¼ of 1 per cent set aside from each for the disability program. But it is now estimated that the program will run a deficit of $146,000,000 this year.

These salient facts are mentioned only to point out that future Social Security tax increases are imminent and to question the wisdom of adding to this tax burden by increasing the annual taxable wage base from $4800 to $5200 and adding another ½ of 1 per cent rate increase as provided in H.R. 3920. Recall, that when the Social Security program began in 1937, the maximum annual tax was $30, each for the employer and employee. At present, it is $174. By 1968 it will be $222—if no changes are made in the law.

However, the tax provisions in H.R. 3920 would further increase it to $253.50, a total of $507 for the combined employer, employee tax. For a self-employed individual, with an annual income of $5200, the tax would amount to $379.60 (7.3 per cent).

These added costs might well jeopardize our entire Social Security program. Let us keep this program *secure* rather than create additional deficits to provide benefits to millions of people who don't need them.

Reduce Quality of Medical Care

There is general agreement that American medicine is the best in the world. Legislation using the Social Security mechanism to provide health care for the aged would lead to overtaxing of doctors and facilities as it has done to an astounding degree in Great Britain where experience has shown undeniably that the public uses facilities more when they think such care is "free." Under such a program, the federal government would be purchasing services and it would have to control the cost of these services to safeguard the taxpayer's money. It would be compelled to set rates for these services and enforce standards of hospital and medical care with attendant administrative controls the would discourage individual initiative in health matters and lower incentives for improved services.

Summary

In summary, the following are some of the reasons the Illinois State Chamber of Commerce urges your rejection of legislation to provide medical and hospital care for the aged under the Social Security program as proposed in H.R. 3920. (1) The need for such legislation does not exist. This care is available through the Kerr-Mills program, private health insurance plans and other voluntary programs which have shown phenomenal growth in recent years and which should be encouraged rather than undermined. (2) The initial costs, while staggering, portend potential costs that might well jeopardize the entire Social Security program. As indicated by former Congressman Aime Forand, sponsor of the original Forand Bill with similar provisions, the limited benefits would be expanded after the "foot is inside the door" with resulting snowballing of costs. (3) Such a mandatory program would destroy individual incentive which has made American medicine the world's finest, thus lowering the quality of our medical care. (4) The legislation is contrary to the traditional American philosophy of letting government do only what the citizens cannot do better for themselves.

Latest Placement Service Listings

The Illinois State Medical Society Placement Service encourages inquiries from physicians interested in locating in Illinois communities. Among the towns listed with the service are:

Adams County: Golden, population 491; estimated population of trade area, 2,500. Only physician died recently. Nearest physicians at Clayton, Bowen, Augusta and Quincy—9, 10, 13 and 32 miles. Two physicians within 10 miles. Nearest hospital at Quincy, 32 miles, population: 43,300. Attractive office building of deceased physician for sale. Records available for new physician. Financial assistance available. Principal source of income: agriculture.

Bureau County: Wyanet, population 1,020. Community without a resident physician since 1962. Nearest physicians at Princeton, 6 miles, and Sheffield, 10 miles. Nearest hospital at Princeton, 125 beds. Also Prairie View Nursing Home, 150 beds. 50 miles from Peoria. Office facilities available. Financial assistance can be arranged if desired. Agricultural and industrial community.

Ford County: Melvin, population 550. Estimated population of trade area, 3,000. Town without a physician since 1961. 2 physicians within 10 miles. Nearest hospital at Cibson City (Cibson Community) 11 miles. Nearest city, Champaign, 35 miles. Office of former physician available. Agricultural community.

Henry County: Calva, population 3,060. Two physicians; third physician moved recently, fourth physician recently retired. Replacement needed. Nearest hospital at Kewanee, 11 miles, Kewanee Public, 100 beds. Office space available (has been occupied by a physician for many years). Principal sources of income: industry (9 small industries) and agriculture.

Iroquois County: Buckley, population 700; estimated population of trade area: 3,500. Physician needed to replace only physician who died August 1962. Nearest physicians, 10 miles, at Paxton, Cissna Park and Roberts. Nearest hospitals, 10 miles. Nearest large city: Champaign-Urbana, 35 miles; total population, 74,000. Eight room fully equipped office building available, built 5 years ago. Agricultural community.

Johnson County: Coreville, population 650. 6 small towns in trade area without physicians. Nearest physicians at Marion and Vienna (2 physicians), 14 miles. Nearest hospital at Marion—Marion Memorial, 68 beds; 60 miles from Paducah, Kentucky. Office space and housing available. Agricultural area; limited amount of industry; 25 small businesses.

Knox County: Altona, population 500. Several small towns in immediate area without physicians. Only physician in 10 mile radius, a woman, is leaving due to transfer of her husband to another area. Nearest hospitals at Galesburg, 16 miles, Cottage and St. Mary's. Nearest large cities, Peoria and Rock Island-Moline, 45 miles each. Office building and equipment available. Financial assistance can be arranged if desired. Agricultural community.

Lawrence County: Bridgeport, population 2,500. Estimated population of trade area: 5,000. One physician, age 55; urgent need for a second. Nearest hospital at Lawrenceville, 4 miles; Lawrence County Memorial Hospital; 65 beds. Nearest large city, Evansville, 65 miles; population 75,000. Active Lions Club is sponsoring plans to secure a second physician. Sources of income: oil and agriculture.

Maeon County: Macon, population 942; estimated population of trade area: 5,000. Several small towns in surrounding area without physicians. (Elwin, Dalton City, Boody and Walker). Nearest physicians at Moweaqua, 7 miles, Blue Mound, 7 miles, and Decatur, 10 miles. Only physician died in 1959. 2 physicians in a 10 mile radius. Nearest hospital at Decatur, 12 miles. St. Mary's and Decatur and Macon County; 225 and 330 beds. Open staffs. Population, 75,000. Office and equipment available. Financial assistanee for a physician desiring same could be arranged. Agricultural and industrial community.

Macoupin County: Cillespie, population 4,200. Estimated population of trade area: 12,000. Several small towns in immediate area without physicians. Two physicians, ages 54 and 50; need for a third; nearest hespital at Litchfield, 10 milcs. Nearest large city Alton, 40 miles. Financial assistance can be provided if desired. Sources of income: agriculture, Chemical Corporation, Shell Oil Company and Standard Oil Company. Need for a physician verified by county medical society.

Inquiries and comments should be directed to: Mrs. Robert Swanson, Secretary, Physicians' Placement Service, Illinois State Medical Society, 360 North Michigan, Chicago 1, Illinois.

Mr. Harold Widmer, ISMS Legislative Representative, who is frequently in the field also has a listing of openings in the State. He may be contacted when he is in your area or at the ISMS Springfield office.

Literature Available

without charge to the membership



Division of Medical Services and Economic Research

1. **New Tax Saving Plans for Self Employed** (HR-10—Self-Employed Individual Tax Retirement Act of 1962).
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ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT

The Illinois Medical Assistants Association is seeking the help of ISMS members in raising the professional standards of the state's medical assistants. A unique program, instituted to give the qualified medical assistant the opportunity to pass a special board examination, is described below.

The aims of the American Association of Medical Assistants and the Illinois chapter have been lauded by both the AMA and ISMS. All Illinois physicians are urged to encourage their medical assistants to become a part of this educational organization.

Certification examinations for medical assistants will be held the last Friday and Saturday in June. Application forms may be obtained by writing to the American Association of Medical Assistants, 510 North Dearborn Street, Chicago 10, Illinois (Attn: CEC). Deadline date for return of application form is February 1, 1964.

To be eligible to take the examinations the applicant must be a High School graduate and be at least 21 years of age on February 1, 1964. She must have a minimum of three years experience in the office of a doctor of medicine, hospital or clinic. She must have at least 12 months experience with one doctor, hospital or clinic. She must request her employer to submit a brief letter of reference which should include opinions as to the applicant's readiness for such testing, work impressions and general capabilities. This letter should not accompany the application but should be mailed directly by the employer to the above address. **Membership in AAMA is not a requirement for certification testing.**

Application fee of $5.00 must be submitted with the application, and is not refunded unless applicant is determined ineligible by the Certifying Board.

Examination fee is $7.00 per Section, payable upon receipt of notice of acceptance.

No refund of the examination fee will be made unless notice of the withdrawal is received prior to May 15th in which case one-half of the examination fee paid will be refunded or applied to examination in the following year, at the option of the applicant. No refunds will be made until after July 1, 1964.

A candidate for certification must take the entire examination for one of the two classifications on the first attempt. If at least two sections are passed the remaining sections may be repeated in a subsequent year upon payment of $7 for each section to be retaken. All 5 sections must be passed within a four year period in order to be considered for certification. No application fee is required on retake examinations.

Contents of the examination:

Section I.	Medical Terminology, Anatomy & Physiology.
Section II.	Personal Adjustment and Human Relations; Medical Ethics & Etiquette.
Section III.	Medical Law & Economics.
Section IV.	Office Skills and Procedures; Accounting; Credits & Collections.
Section V.	Written & Oral Communications; Records, Medical and Non-medical.
Section VI.	Examination Room Techniques; Sterilization Procedures; Care of Equipment; Immunology and Injections.

Section VII. Laboratory Orientation (Urinalysis, Hematology and Bacteriology) X-ray, Electrocardiography, Basal Metabolism and Physiotherapy.

Candidates for **Medical Assistant, Administrative,** must successfully pass Sections 1, 2, 3, 4, 5. Candidates for **Medical Assistant, Clinical,** must successfully pass Sections 1, 2, 3, 6, 7. Any candidate may apply for all 7 sections if desired.

The Board will attempt to arrange test centers geographically convenient to a suitable nucleus of eligible candidates, the number of test centers to be expanded annually in conformance with interest in the examination and facilities available.

ISMS Annual Convention

May 17-21

General Assembly Speaker



Dr. Hugh H. Hussey

Hugh H. Hussey, M.D.

Director, Division of Scientific Activities

American Medical Association

"Problems Related to New Drugs"

Wednesday, May 20

Ballroom **Sherman House**

Wednesday Is Chicago Doctors' Day!



Surgery. Richard Warren, et al. $19.50. Pp. 1397. Philadelphia, W. B. Saunders Company, 1963.

For those who remember John Homan's textbook of surgery, this volume becomes a worthy successor. For those who do not, this will set the standard against which to measure future texts. It is astounding to realize that a single surgical department could produce this compendium, that a single artist could so clearly illustrate so many of the major points. Yet it is these two facts that give this large volume character, continuity, and a distinct personality. It has these and is more; an authoritative summary of clinical surgery today.

There is much to commend in this presentation. The paper is not glossy, it is easily read. There is no hodgepodge of photographs, x-ray films and diagrams; merely clear line drawings done with restraint and obvious purpose. The historical summaries, so important in a student text, are contained within the individual sections rather than relegated to the introduction or to the end, never to be read after medical school. The authors, Cope, Dunphy, Warren, Francis Moore, and others represent the best teachers in surgery. Their presentations are not stuffy, are easy to read and to enjoy.

This book will freshen any surgeon's book shelf. It will be more appreciated by practitioners than by students for the former will read it by choice, the latter by assignment.

John J. Bergan, M.D.

Medical Residents Manual. Frank B. Flood, Richard J. Kennedy and William J. Grace. $4.95. Pp. 311. New York, Appleton-Century-Crofts, 1963.

This book is designed to replace the loose leaf notebook carried by students, interns and residents. The manual covers a wide range of material in a well summarized form. The subject matter is arranged in alphabetical order for easy reference. Tables of normal values and diagrams are also included.

The major fault of the book is, that while it contains a greater amount and more accurate information than the "pearl book," it nullifies a large portion of a notebook's value. The notebook is filled through the reading of texts and journals and thru experience with patients. This manual eliminates the necessity for reading.

David C. Bachman, M.D.

Office Procedures. Paul Williamson. $13.50. Pp. 448. Philadelphia, W. B. Saunders Company, 1963.

This book is primarily designed for the general practitioner with an office away from a metropolitan area. It covers practically every exigency likely to arise in any field of medicine. The book gives good coverage of most common office procedures with diagrammed illustrations of methods. The suggested equipment and apparatus are intentionally simplified so that they will be easily available anywhere. The discussions of theory concerning the procedures are necessarily limited and occasionally debatable. A few of the procedures are outdated but, generally, all are useful.

If the reader is able to overcome the shock of contemplating the performance of some of the procedures in the office, he will find this a useful book.

David C. Bachman, M.D.

An Atlas of Hemodynamics of the Cardiovascular System. Howard Bell Moscovitz, et al. $11.75. Pp. 277. New York, Grune & Stratton, 1963.

This volume is a compilation of angiocardiograms, intracardiac pressure tracings with pulmonary arterial and aortic pressure tracings, and intracardiac phonocardiograms, together with a brief descriptive text for each illustration. The material is chiefly derived from experimental observations on dogs and covers a wide range of anatomic and physiologic problems ranging from consideration of the normal, to acquired valvular disease, pericardial disease, and various congenital defects. A section is included on atrial and ventricular arrhythmias and A-V block. This is obviously a large order for a book with only 277 pages, and the authors have not entirely succeeded. The volume is most useful as a presentation of highly interesting and helpful



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

physiologic studies of various cardiac lesions produced in the dog. On the whole, the illustrations are clear and well labeled and instructive.

The authors are less successful when they endeavor to go beyond these experiments and describe the clinical and even therapeutic aspects in the human. Here, the comments are too brief to be helpful and they are on the whole inappropriate for a volume of this type. Thus, the single paragraph on digitalis intoxication on Page 220 and the paragraph on ventricular arrhythmias on Page 224 are too brief to be informative. However, the book can be recommended for its valuable illustrations of various normal and pathologic physiological processes involving the cardiovascular system. It may be commented that the most common of all the cardiovascular diseases, acquired coronary artery disease, receives only three pages of discussion, the problems of hemodynamics in hypertension are not included, and myocarditis is likewise not discussed.

Oglesby Paul, M.D.

Nutrition and the Heart

The Illinois State Medical Society and the Illinois Heart Association, realizing that nutrition is increasingly important in the management and prevention of heart disease and the resulting controversy, will sponsor a special conference for physicians, nurses, dieticians, and other interested persons. Representatives of biochemical fields, nutrition research, the food industry, and clinical medicine will present the program and attempt to clarify what is known and unknown in this field.

Jacksonville, Illinois *February 27, 1964*

Program:

Afternoon Session

Chairman, James R. Wilson, M.D.

1:30—Registration—Dunlap Motor Inn, Jacksonville

2:15—"Metabolic Aspects of Nutrition and the Heart"
Fred A. Kummerow, Ph.D., Urbana, Illinois
Director of Burnsides Research Laboratory, University of Illinois

2:45—"Epidemiological Aspects of Diet and Heart Disease"
George V. Mann, Sc.D., M.D., Nashville, Tennessee
Career Professor, NIH, Vanderbilt University

3:15—"What is Happening to the Fatty Acid Composition of Commercial Edible Fats, Oils, and Margarines"
E. M. Deck, M.Sc., Dallas, Texas
Vice President, Product Development, Anderson-Clayton and Company

3:45—"Clinical Aspects of Nutrition and the Heart"
Richard J. Jones, M.D., Chicago
Associate Professor of Medicine, University of Chicago

4:15—General Discussion and Questions

Evening Session

Chairman: Frank B. Norbury, M.D., Jacksonville

6:30—Dinner

Principal Address:
"An Illustrated Tour of Central Africa —Cross-Cultural Studies of Coronary Disease"
George V. Mann, Sc.D., M.D., Nashville, Tennessee

Advance registration may be made by writing Mrs. Lucille Lair, Nutrition Meeting, P.O. Box 452, Jacksonville, Illinois before February 1, 1964. Please indicate places for the afternoon session (no fee); places for dinner and evening session ($3.00 per person). A tour of the Anderson-Clayton and Co. Foods Division plant is available offering an opportunity to see how edible fats and oils are made into products for daily home use.

join the ISMS post-convention

MEXICO TRAVEL ADVENTURE TRIP

May 21-25, 1964

Following ISMS Chicago Convention May 17-21, 1964

SAVE OVER $100.00 PER COUPLE—

*SPECIAL GROUP RATE TRAVEL PLAN

TRAVEL VIA ROUND TRIP JET — CHICAGO/MEXICO CITY/ CHICAGO for only $160.50 PER PERSON

*Group of 25 or more must travel together to Mexico City but *may return on their own at any time.* Air rate subject to C.A.B. approval. (Regular jet tourist round trip air rate—$214.00)

MEXICO CITY POST-CONVENTION PROGRAM COST PER PERSON: *Double .....$94.45 Single .....$118.45. Highlights of program include: FOUR NIGHTS/FIVE DAYS at famous Maria Isabel Hotel . . . transfers, baggage handling, gratuities in Mexico City . . . specially planned social events . . . breakfasts . . . sightseeing . . . pre-trip services for air routing, reservations, baggage, guest coupons, ticketing, documentary papers. (*Based on sharing twin-bed room)

EXTENSION TRIP TO CUERNAVACA, TAXCO, ACAPULCO includes many exciting features and is available, May 25-28. COST PER PERSON: Double .....$99.00 Single .....$120.00.

FILL IN COUPON BELOW AND MAIL TODAY!

Upon receipt of coupon with deposit (Make Check Payable: Illinois State Medical Society Travel Headquarters), letter of confirmation, official reservation form and itinerary will be sent to you. DEPOSIT IS REFUNDABLE IN FULL 30 days prior to departure time. Thereafter, service charge of $10.00 will be deducted from refund.

Illinois State Medical Society
Mexico Travel Headquarters
36 S. Wabash Avenue — Suite 1301
Chicago, Illinois 60603

☐ Please make my reservations for the Mexico City Post-Convention program and GROUP RATE transportation. Enclosed is my deposit check in the amount of $_____ ($25.00 per person) covering _____ in my party.

☐ Please place me on your mailing list to receive itineraries and official reservation form on the Mexico City Post-Convention and Extension Trip to Cuernavaca-Taxco-Acapulco for my consideration.

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE NO. _____ ISMS #1

NEWS and ANNOUNCEMENTS

ISMS Foundation Plans Film, Issues Water Conditioning Report

The directors of the Educational and Scientific Foundation of ISMS have announced the completion of one project and the inauguration of another under it auspices.

Water Project

The study of the relationship of soft water to heart disease conducted under the direction of Dr. James Wilson, Winnetka, has been completed (See report on page 25). At a special meeting held in the ISMS Executive offices, Dr. Wilson presented the completed report to representatives of the Water Conditioning Council, sponsors of the project.

The study was instituted to investigate fully the contradictory reports appearing in the scientific literature regarding the relationship between soft water and heart disease. The other consultants were Dr. Abel Wolman, Johns Hopkins University; Dr. William Strain, School of Medicine and Dentistry, University of Rochester; Dr. W. H. Sebrell, Jr., Columbia University Institute of Medical Science; Dr. Oglesby Paul, M.D., Passavant Memorial Hospital; and Dr. John Dingle, Preventive Medicine, Western Reserve, University.

Multiple Birth Film

A 20 minute color film showing the birth of the Chicago Harris quadruplets will be produced by the Foundation and sponsored by Lederle Laboratories. The films were taken by Dr. Norman Brill during the births at Michael Reese Hospital last summer. Technical advisors for the film will be Dr. Allen Charles and Dr. William Alpern, attending physicians at the births. (See the August issue of IMJ for the complete report.)

The film emphasises the prenatal care necessary in multiple births and the establishment of identicalness. The film is expected to have wide scientific and teaching value.



TECHNICAL ADVISORS for the film in preparation featuring the birth of the Harris Quads, Drs. Allen Charles (left) and William Alpern (center) meet with film producer Murray Morison. On the table before them is the plastic mold containing the four placentas from the deliveries of the quads.

(continued on page 88)

PULSE of the Illinois State Medical Society

January, 1964 A Service of the Public Relations Division

Physicians Champion Medicine's Public Image

Record 110 Hours Radio-TV Time in '63!

"Congratulations . . . well done!"

The ISMS Public Relations Committee has voiced this praise for the 70 ISMS physicians who appeared on radio and TV in 1963 to help roll up a staggering 102 hours of public service broadcast time—more than five times the society record for any previous year.

"The value gained from this exposure in terms of winning friends for medicine and educating the public on medical problems cannot be overestimated," announced PR Committee Chairman Dr. Leo P. A. Sweeney.

"Equally important, it demonstrates that the physician himself is medicine's greatest champion."

In establishing the new record, ISMS' radio-TV speakers' bureau supplied physician guests for virtually every discussion and interview-type show on the local airways:

*WBBM's *Conference Call* and *Freda Kehm Show.*

*WAAF's *Weekend Show.* (Moderator Phil Lind features more medical interviews than any other TV or radio personality, records show.)

*WJJD's *Let's Talk It Over.*

*WIND's *Perry Marshall* and *John Dreiske* shows.

*WBBM-TV's *Lee Phillip, Six O'Clock Report* and *Seven O'Clock Report* shows.

*WBKB's *Lynn Walker Show.*

In addition to supplying guests, ISMS created and produced important programs of its own:

**MEDICAL INTERVIEW*, five-minute discussions pre-taped for broadcast each week on WGN in Chicago and 27 stations in Illinois. Guests include dentists, druggists, lawyers and engineers to demonstrate the relationship between medicine and other professions.

**SAFEGUARD YOUR HEALTH*, a one minute TV spot starring Burgess Meredith.

**10-SECOND STATION BREAK SLIDES* bearing important health reminders. Together with *Safeguard*, the slides have been distributed to all 18 TV stations in Illinois.

**TODAY'S HEALTH TIP*, 30-second radio spots featuring ISMS' immediate past president Dr. George F. Lull. Aired 4 times daily over WJJD for 11 of the past 12 months, the show has brought Dr. Lull into Chicago area homes more than 1,000 times in 1963. "It has become so popular," said WJJD news director Reese Rickards, "that we plan to reschedule it in '64."

**MEDICAL SELF-HELP*, a 16-week TV course on emergency medical care which began last Oct. 10 on station WTTW. More than 10,000 Chicago area citizens have enrolled in the course, and films will be made available to schools, industries and other TV stations throughout the country.

"Series narrator Dr. Max Klinghoffer has appeared on TV more than 30 times in 1963, making him one of our outstanding TV personalities for the year," Dr. Sweeney said.

New programming plans for 1964 include a weekly TV medical news show; TV animated health tips; and an hour-long panel discussion show on Chicago's new UHF Channel 26, he stated.

"Our accomplishments for 1963 would not have been possible without the superb cooperation of radio and TV stations throughout Illinois," Dr. Sweeney said.



INCREASINGLY COMMON SIGHT THESE DAYS are ISMS physicians making radio, TV and personal appearances. Here Drs. J. Ernest Breed, center, and Norman Cross, right, square off to answer questions on the John Dreiske show broadcast Dec. 8 over Chicago radio station WIND. Mr. Dreiske, at left, is noted news columnist for Chicago Sun-Times.

AMA-ERF Loan Fund



A CHECK FOR $185,000 is presented by ISMS President Dr. Harlan English, left, to Dr. Raymond McKeown, Chairman of the American Medical Association Education and Research Fund during the AMA Meeting in Portland Dec. 3. The money is allocated from the ISMS dues structure to provide loans for the five medical schools in Illinois. Over the past 13 years ISMS has contributed over $2 million to the fund to lead all other states.

For Benevolence . . .

Excerpts from letter sent to County Rural Health Chairmen by State Chairman Mrs. Eugene Vickery:

One of the very best ways to improve rural health is by education of the people. We have an excellent way to do this by distributing pamphlet material in a fine gold and black literature rack that has been most generously made available to us through ISMS. The racks with pamphlets are yours for only $1.00 each. Have you ever seen such a bargain! Donations are to Benevolence, and your county gets the credit. Send your orders to me for delivery right away.

Mrs. Eugene Vickery
Rural Health Chairman
602 Oak Street
Lena, Illinois

COMMUNITY SERVICE IN 1964

Our state president, Mrs. Uznanski, has chosen as our theme for the year "The Art of Giving".

As individuals we can give of our time and talent. Most of us are active in other organizations, and thus the opportunities to practice community service arise almost daily. It is said that service is the rent we pay for the space we occupy in the community and as doctors' wives we are uniquely qualified to lend support to worthwhile community-sponsored health activities. The public considers us knowledgeable concerning health matters and looks to us to counsel them wisely. Therefore, we MUST be well informed as to the health needs of our community. We must know about approved medical programs and services

Here is where membership in our medical auxiliary is vital. We can use the auxiliary as a clearing house—here we can learn what to do and how to do it. We can receive the information from the hundreds of pamphlets and booklets issued by the AMA which are available to all of us.

A community service project with which the national auxiliary is particularly concerned this year is the homemaker service program. This service helps aged people to stay in their own homes and keeps families together when illness strikes.

Many of our auxiliary community service projects will be similar to those of other community groups interested in health and welfare problems. Cooperate with these groups as much as possible. Choose only the project or projects which meet your community need. Do not attempt to do everything that has been or will be suggested.

And most important of all—before planning your community service program in your local county consult with the advisor from your medical society, your own president and program chairman, and study your community needs. Be guided by these needs, the recommendations of your medical society, and the interest of your members. Without enthusiasm on the part of the membership of your auxiliary no project will be carried out effectively.

Dr. David B. Allman, past president of the AMA, once said: "Whenever and wherever a woman's auxiliary has been given the direction and opportunity to serve the profession or the community, there have been visible, impressive results. . . . An auxiliary member is a tireless worker; she backs away from no task when she is inspired to a cause. She is devoted, selfless, unstinting of her time, creative, clever, practical and resourceful." Here is a real challenge!

Mrs. Newton DuPuy
Community Service Chairman

! ATTENTION !
CMS AUXILARY ARTISTS

Time for your second Art Exhibit is here! Time is March 2-5 at Palmer House (in conjunction with CMS Clinical Conference).

All paintings, media and sculpture will be accepted, so decide on your entries NOW!

. . . and More For Benevolence

The following excerpts were from a letter to Mrs. Uznanski from the ISMS business office:

Many copies of "History of Medicine in Illinois, Vol. 2" have been purchased this year through the efforts of the Woman's Auxiliary and this effort is greatly appreciated by the Society.

In the future, each copy sold for $10 will be recognized in the form of a contribution by the Society to the Benevolence Fund in the amount of $5. This contribution will be recorded to the credit of the Woman's Auxiliary. Since there are roughly 330 volumes remaining in stock, the potential contribution may reach $1,650.

How Should Animated Symbol For ISMS Doctor Look?



Consoling?



Assertive?



Suave?

An animated symbol for ISMS is the topic of much discussion by the PR Committee and staff these days—and the reasons are not as frivolous as they seem.

"Like any organization, ISMS can strengthen its indentity and public image with an eye-catching, appealing and representative memory symbol," explained Dr. Leo P. Sweeney, PR Committee Chairman.

When this symbol is selected, Dr. Sweeney pointed out that it will establish graphic continuity for the expanded 1964 PR program.

"We plan to introduce the character on a new five-minute 'Medical Health Tip' series then gradually extend its use to outdoor billboard messages, pamphlets, news release stationery and logo types for ISMS newspaper features.

"The selection of a truly representative symbol is difficult, and in the end we may resort to a live actor," Dr. Sweeney explained.

In the meantime, the three cartoons illustrated on this page have been submitted for consideration. Which, if any, would you like to see as a symbol for ISMS? The Pulse would appreciate hearing your opinion.

Princeton Physician "Internationalizes" Public Relations for Illinois Medicine

A one-man international PR "program" for Illinois medicine returned home from Europe Jan. 10 in the amiable person of Dr. Julius M. Kowalski, Princeton physician, Chairman of the ISMS Public Safety Committee and nationally known outdoor writer.

Asked by AMA earlier in the year to be its representative at the Latin Medical Conference in Rome Dec. 18-21 and at the British Medical Society Meeting in London Jan. 2-4, Dr. Kowalski spoke to both assemblies on "Medicine in Relation to Outdoor Recreational Pursuits."

A nationally—and now internationally—recognized authority on outdoor medicine, Dr. Kowalski is best known to the ISMS membership for his "Medicine in the Out-of-Doors" series which appears as a regular feature in the Illinois Medical Journal. This series begins its fourth year in 1964.

Dr. and Mrs. Kowalski left Chicago by jet on Dec. 14 for a European tour that included visits to Italy, Switzerland, Germany, France and England. Upon their return Jan. 10, Dr. Kowalski reported on the two conferences to AMA.

(See next month's PULSE for a summary of Dr. Kowalski's report.)



DR. JULIUS M. KOWALSKI

Our "PR man" in Europe

COUNTY CAPSULES

ADAMS COUNTY physician Dr. E. Newton DuPuy, ISMS Board of Trustees Chairman, was promoted last month to the rank of full colonel in the medical service of the Illinois National Guard.

DUPAGE COUNTY hosted the Third International Convention on Missionary Medicine held at the Wheaton College Campus Dec. 20-22. Nearly 500 physicians, dentists and medical missionaries from all around the world gathered for the conference.

GREENE COUNTY Medical Society's Resolution on President Kennedy's death was passed unanimously by AMA House of Delegates during their session in Portland, Ore. Dec. 2-4.

TAZEWELL COUNTY Medical Society's new president is Dr. Robert L. Tucker, Pekin. The society's newly named secretary-treasurer for 1964 is Pekin physician Dr. Harry Sheperd.

DUPAGE COUNTY physician Dr. James B. Hartney has been named by Gov. Kerner to a 5-man commission to study blood banks and clinical laboratories. Dr. Hartney is Chairman of the Laboratory Evaluation Committee of ISMS.

SANGAMON COUNTY Medical Society conducted a seminar on problems of alcoholic rehabilitation at its monthly meeting Dec. 10.

MARION COUNTY Medical Society made available 2,000 diabetes detection kits to the public in a drive to detect the disease and encourage early treatment during Diabetes Week, Nov. 11-20.

HENRY COUNTY Medical Society has awarded diplomas to 47 adults of the Galva area on their completion of a 5-week Medical Self-Help Training Course. The course was presented by the society and the Galva Civil Defense Agency.

World Recognition For Stroke Film

Latest chapter in the phenomenal success story of the ISMS film "Stroke—Early Restorative Measures in Your Hospital" occurred Oct. 13-19 when it was shown at the international film exhibition held during the 17th World Medical Assembly in New York.

Since its completion early in 1963, the 20 minute, 16 mm. color film—produced by the ISMS Committee on Aging in Cooperation with the Illinois Department of Public Health—has won national plaudits as a basic teaching film on early management of stroke patients upon hospital admission.

Dr. Edward E. Gordon, Head, Dept. of Physical Medicine, served as medical consultant and principal participant in the film.

To date 40 of the films have been sold to hospitals, universities and medical centers in this country, and many more are currently being previewed. One of the films has been sold to a hospital in Canada and another is being previewed by a hospital in Denmark.

Dr. E. W. Cannady, Chairman of the Committee on Aging, explained that the primary purpose of the film is to "inform physicians and nurses and to stimulate action and interest in constructive rehabilitation in all hospitals."

Copies of the film are available without charge for previewing by writing the Committee on Aging, Illinois State Medical Society, 360 North Michigan Avenue, Chicago 1, Illinois. Purchase price is $125.00 per copy.



CERTIFICATE OF PARTICIPATION in international film exhibition is proudly accepted for Stroke film by Dr. E. W. Cannady, Chairman of ISMS Committee on Aging.

cut Rx writing by 2/3 in colds, flu or grippe

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ADDRESS _____

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No need to write three separate prescriptions for antitussive, decongestant and analgesic relief of common cold, flu or grippe symptoms when it is therapeutically correct... economically sound... to specify

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Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
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*Warning—may be habit forming

'Emprazil-C' Tablets are available on prescription only.

Dosage: Adults and children over 12 years—1 or 2 tablets—3 times daily as required. Children 6 to 12 years—1 tablet—3 times daily as required. **Caution:** While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed. **Supplied:** Bottles of 100 tablets.

Also available without codeine as 'EMPRAZIL'® TABLETS

Complete literature available on request from Professional Services Dept. PML.

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State Maternal-Infant Health Congress Planned

The Eighth Illinois Congress for Maternal and Infant Health will be held at the St. Nicholas Hotel in Springfield, February 5-7. The theme for the meeting is "Science, Service and Sentiment of Maternal and Infant Health."

Among the speakers will be Dr. Herbert Philipsborn, Chairman, ISMS Committee on Perinatal Mortality who will speak on "Fetus and the Newborn"; Dr. Morris Fishbein—"Appeal for Maternal and Child Health" and "Fifty Years of Maternal and Child Care"; and Dr. Robert Hartman, Chairman, ISMS Committee on Maternal Welfare, who will join a panel with Dr. James Fitzgerald and Dr. Edward M. Dorr on "Reduction in Maternal Mortality—Are We Doing All We Can?"

The Banquet Speaker will be Betty Friedan, author of the "Feminine Mystique" and the Summation Luncheon Speaker is Dr. John Rock, Boston, author of "The Time Has Come."

Special panels on "Sex Education—Whose Responsibility?" and "Sex Education and Venereal Disease" are planned.

A complete program and registration forms are available from the Illinois Association for Maternal and Infant Health, c/o American Association for Maternal and Infant Health, 116 South Michigan, Chicago, Illinois 60603.

Elections

Dr. Samuel B. Nelson, Chicago, has been elected president of the Illinois Academy of General Practice. Dr. Nelson is also president of the medical staff of Grant Hospital, Chicago.

Dr. George J. Rukstinat, Chicago, has been re-elected trustee of the American College of Gastroenterology.

Dr. Herbert Sohn of Deerfield is the new president of the Alumni Association of the

In rheumatoid arthritis



Patient: 56-year-old woman with generalized rheumatoid arthritis of 7 years' duration. **X-ray:** Skin prepared with barium sulfate; tube distance 36 inches, 50 ma. sec. at 40 kv.; no screen.

Chicago Medical School. Dr. Sohn was a member of the class of 1955.

Dr. Warren Pearce of Quincy has been re-elected president of the Swanberg Medical Foundation of the Adams County Medical Society.

Appointments

Governor Kerner has appointed a Commission on Clinical Laboratories, Blood Banks, and Blood Bank Depositories as authorized by the 73rd General Assembly. Physicians on the committee include Dr. James B. Hartney, chairman of the ISMS Laboratory Evaluation Committee; Dr. Albert Wolf, M.D., medical director of the Michael Reese Research Foundation representing hospital operated laboratories; and Dr. Paul Van Pernis, Rockford, representing privately owned blood banks. Privately owned clinical laboratories and hospital operated blood banks and blood bank depositories are also represented.

Dr. R. Vincent Kron, LaGrange Park, has been named medical director for IIT Research Institute.

Two major appointments in pediatrics and in obstetrics and gynecology have been announced jointly by The Chicago Medical School and Michael Reese Hospital and Medical Center. The appointments are:

Dr. Jack Metcoff internationally recognized for his investigations in body fluid physiology and kidney disease, who becomes chairman of the department of pediatrics at the Chicago Medical School. Since 1956, he has been chairman of pediatrics at Michael Reese, a position he will continue to hold.

Dr. Emanuel A. Friedman, the author of a number of reports on labor in childbirth and an investigator of cerebral palsy and other neurologic disorders associated with birth, who as-

the 'right' steroid

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CLINICAL EXCELLENCE...

AT SUBSTANTIALLY REDUCED COST TO THE PATIENT

Unsurpassed antirheumatic activity DEXAMETH (dexamethasone) is "the most powerful antirheumatic glucocorticoid yet synthesized."[1] It exerts a prompt and potent ameliorating effect in patients with rheumatoid arthritis;[2] symptoms of inflammatory reaction are quickly suppressed in a substantial proportion of patients, joint stiffness is relieved and function improves.

Lower tendency to produce undesired effects DEXAMETH (dexamethasone) is less likely than most other steroids to produce electrolyte imbalance, hypertension, and disturbance in carbohydrate metabolism. Abnormal weight gain may limit the usefulness of the drug in some patients, but may be advantageous in others.

Unusually economical therapy DEXAMETH (dexamethasone) is available at significantly lower cost than many analogous steroids. It is therefore particularly useful for arthritics and other patients whose financial resources are burdened by chronic, incapacitating disease.

product profile—DEXAMETH (dexamethasone) is a glucocorticoid with outstanding anti-inflammatory and antiallergic activity. At therapeutic dose levels, it may have less tendency to cause sodium or water retention, potassium excretion, disturbance in glucose metabolism or hypertension than some of the older steroids. With these exceptions, however, the drug may give rise to the metabolic and hormonal side effects characteristic of corticoids. It should therefore be used with great caution in the presence of tuberculosis and other infections, osteoporosis, peptic ulcer, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, herpes simplex, psychotic tendency, pregnancy and in persons exposed to chickenpox, measles or scarlet fever. It is contraindicated in ocular herpes simplex, arthritis complicated by psoriasis, tuberculosis of the eye and skin, fungal keratitis, and local pyogenic infection.
Before prescribing, consult product brochure.

Dosage: In rheumatoid arthritis, the initial daily dosage ranges from 2 to 4 tablets (1.5 to 3.0 mg.). The dosage is then decreased gradually to the minimum that will maintain sufficient relief; this may be as little as 1 tablet (0.75 mg.) per day. After extended therapy, it is especially important that the drug be withdrawn gradually to allow recovery of normal adrenal function.

1. Boland, E. W.: J.A.M.A. 17:835 (Oct. 15) 1960. 2. Black, R. L., et al.: Arthritis and Rheumatism 3:112 (April) 1960.

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sumes simultaneous chairmanships of the department of obstetrics and gynecology at The Chicago Medical School and at Michael Reese.

With the appointments—fulltime chairmen heading departments both at the school and the hospital,—the academic affiliation of The Chicago Medical School with Michael Reese Hospital and Medical Center as a teaching hospital is being developed and strengthened, the announcement said.

PG Courses

The American College of Physicians has announced three postgraduate courses in the next few months. "Hypertension and Its Complications" will be offered February 10-14 at the Medical College of Georgia in Augusta. "Recent Advances in Metabolic Diseases" is the title of a course being offered February 24-28 at Mount Sinai Hospital, New York. The third course is entitled "Neurology for the Internist" and will be offered March 2-5 at the Mayo Clinic, Rochester, Minnesota. Complete information is available from the College, 4200 Pine Street, Philadelphia 4, Pa.

A postgraduate course in Gynecologic Endocrinology will be held at Michael Reese Hospital and Medical Center by the Department of Research in Human Reproduction, Dr. J. J. Gold, Chairman. The course will be held Monday, March 2 through Thursday, March 5. The faculty will be composed of members of the Michael Reese Departments as well as invited guests. The program is acceptable for 32 hours credit by the American Academy of General Practice. Further information and description of the program can be obtained from the Department of Medical Education, Michael Reese Hospital, Chicago, Illinois.

Medical Practice and Mental Health, a practical approach for non-psychiatric physicians will be presented by the St. Louis University Department of Neurology and Psychiatry six Tuesday mornings from February 11 to March 17. Complete information is available from the

protect patients adversely affected by cold air

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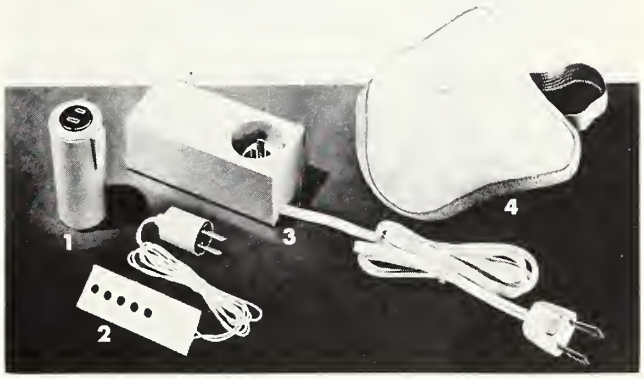


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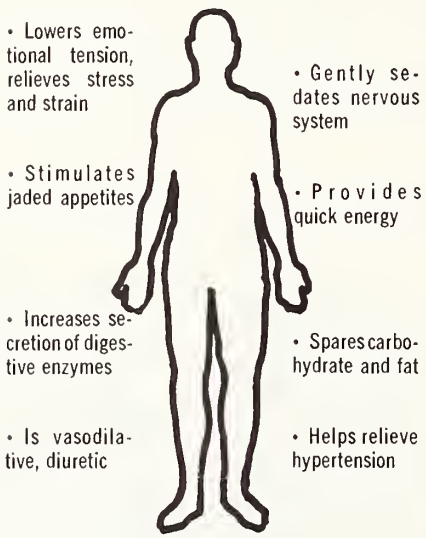
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Staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research will present two three day programs of lectures and discussions on problems of current interest in general medicine and surgery. Category I credit may be obtained through attendance. The number of physicians who can be accommodated is limited, for this reason identical programs will be presented first on March 16-18 and repeated on March 23-25. Complete information is available from the Clinic, Rochester, Minnesota.

Tutorial Program

A nine month tutorial program in Cardiology, September 15, through June 15 will be offered by the Institute for Cardiopulmonary Disease, Scripps Clinic and Research Foundation, La-Jolla, California. This will be an intensive program covering the field of cardiovascular diseases and is especially designed for the physician in private practice who wants a year of organized instruction with freedom from direct patient responsibility. For details, write: E. Grey Dimond, M.D., Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, LaJolla California.

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February 6 Hinsdale—Hinsdale Sanitarium
February 7 Chicago Heights (Cardiac)—St. James Hosp.
February 11 Peoria (General)—Children's Hospital
February 11 East St. Louis—St. Mary's Hospital
February 12 Champaign-Urbana — McKinley Hospital
February 13 Springfield (General)—St. John's Hospital
February 13 Anna—Anna Community Hospital

February 13 Macomb — McDonough District Hospital
February 14 Evanston—St. Francis Hospital
February 18 Belleville—St. Elizabeth's Hospital
February 19 Chicago Heights (General)—St. James Hospital
February 20 Rockford — Swedish-American Hospital
February 20 Bloomington (General a.m.)—St. Joseph's Hospital
February 20 Elmhurst (Cardiac) — Memorial Hospital of DuPage County
February 21 Chicago Heights (Cardiac)—St. James Hospital
February 25 Peoria (General)—Children's Hospital
February 25 Effingham (Rheumatic Fever & Cardiac)—St. Anthony Memorial Hospital
February 26 Springfield (Cerebral Palsy p.m.) —Memorial Hospital
February 26 Aurora—Copley Memorial Hospital
February 27 Litchfield—Madison Park School

Latest Literature

"Right from the Start" is the title of a new Public Affairs Pamphlet and a related film produced by the Public Affairs Committee on a grant from the U.S. Children's Bureau and made in cooperation with the Conference of State and Territorial Directors of Public Health Education. Both the pamphlet and the film stress the importance of early immunization of children. The pamphlet is available for 25 cents a copy from the Public Affairs Committee, 22 East 38th Street, New York, New York.

The Institute of Physical Medicine and Rehabilitation, New York University Medical Center, has announced publication of Rehabilitation Monograph XXI, Part 2, "Self-Help Devices," by Dr. Edward W. Lowman, clinical director and director of the Institute's Arthritis Self-Help Devices Offices, and Dr. Howard A. Rusk, director of the Institute.

The publication includes illustrations and descriptions of devices especially designed to help disabled persons achieve independence in everyday aspects of living. Among the areas covered are communication and vocations, deal-

(continued on page 96)

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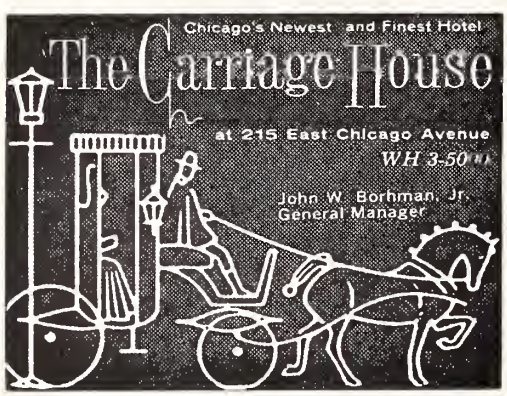


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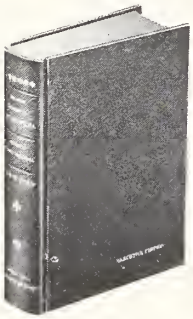
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Copies of the 40-page publication may be obtained for $1.00 by writing to the Publications Unit, Institute of Physical Medicine and Rehabilitation, New York University Medical Center, 400 East 34 Street, New York 16, New York.

Deaths

Hersehel E. Baldwin*, Danville, a graduate of George Washington University School of Medicine in 1905, specialized in ophthalmology. He was on the staff of Lake View Memorial Hospital as well as a Fellow of the American College of Surgeons and a member of the Academies of Ophthalmology and of Oto-Laryngology. He died November 30, aged 80.

J. Harry Bendes*, Rockford, was a graduate of Chicago College of Medicine and Surgery in 1914, and specialized in tuberculosis the last 35 years. A staff member of St. Anthony, Rockford Memorial and Swedish-American Hospitals and Rockford Municipal Sanitarium, he died October 26, aged 74.

Levis C. Brooks*, Rockford, died November 19, aged 59. He was a graduate of Loyola University Medical School of 1936, a member of the Army Medical Corps in World War II and a staff member of Rockford Memorial Hospital.

John A. Colteaux*, Roberts, was a graduate of Chicago College of Medicine and Surgery in 1911. A medical pioneer in Ford County, he retired in 1948 and died November 29, aged 77. He was a member of the Fifty Year Club of ISMS.

Robert W. Glenn*, Canton, was a graduate of the University of Illinois College of Medicine in 1935. A veteran of World War II, Dr. Glenn was on the staff of the Glenn-Maguire Clinic and McKinley Hospital and associate professor at the University of Illinois. He was a fellow of the American College of Surgeons and a founder of both the Midwest Surgical Association and the Illinois Obstetric and Gynecology Association. He died December 5, aged 55.

Harry A. Gussin*, Chicago, died October 30, aged 68. He was a graduate of Rush Medical College in 1927.

Herbert M. Jacobs, Rock Falls, died November 26, aged 58. A graduate of the University of Pennsylvania Medical School in 1933, he served as a medical officer during World War II.

Frank J. Jirka, Sr.*, River Forest, died November 19, aged 77. He was a graduate of Northwestern University Medical School in 1910. A lieutenant in the Army medical corps in World War I, he was attending surgeon on the staff of St. Anthony de Padua hospital from 1924 until retirement and also state public health

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director from 1933 to 1937. An associate professor emeritus in surgery at the University of Illinois school of medicine, Dr. Jirka was a fellow of the American College of Surgeons, the International College of Surgeons, and a diplomat of the American Board of Surgery. He was also a member of the Fifty Year Club of ISMS. His son, Frank, Jr. is a member of the ISMS Board of Trustees.

Charles Papik*, Chicago, was a graduate of Bennett Medical College in 1908, specializing in orthopedic surgery. He was chief of staff at Evangelical Hospital and a staff member of Christ Community Hospital. He was an emeritus member and a member of the Fifty Year Club of ISMS. He died December 1, aged 79.

Andrew B. Rotche*, Chicago, died November 14, aged 67. He graduated from Chicago Medical School in 1922.

Otto Saphir*, Chicago, died November 26, aged 67. Originally from Vienna, he was a graduate of Medizinische Fakultat der Universitat in 1921. Post-graduate work was done at Western Reserve University in Cleveland. Dr. Saphir was a world-known pathologist, noted for research in heart and cancer maladies. He was a founder of the Medical Research Institute at Michael Reese Hospital where he was director of the pathology department. He had been clinical professor of pathology at the University of Illinois College of Medicine since 1930. A diplomate of the American Board of Pathology, he was past president of both Chicago and state pathological organizations.

William Saphir*, Chicago, died November 27, aged 63. Born in Vienna, he graduated from Medizische Fakultat der Universitat in 1925, specializing in internal medicine for which he was licensed in 1943 in this country. He did research work in tropical diseases, endocrine problems and cancer. During World War II he served as a medical corps major. Dr. Saphir was an associate professor at the University of Illinois College of Medicine, a staff member of Michael Reese and Cook County hospitals, and a member of the Society for Internal Medicine and the Institute of Medicine.

William G. Shurtz*, Chicago, a graduate of the University of Illinois College of Medicine in 1926, he was a veteran of both world wars. For 30 years he had been a staff member of Little Company of Mary Hospital where he died November 26, aged 66.

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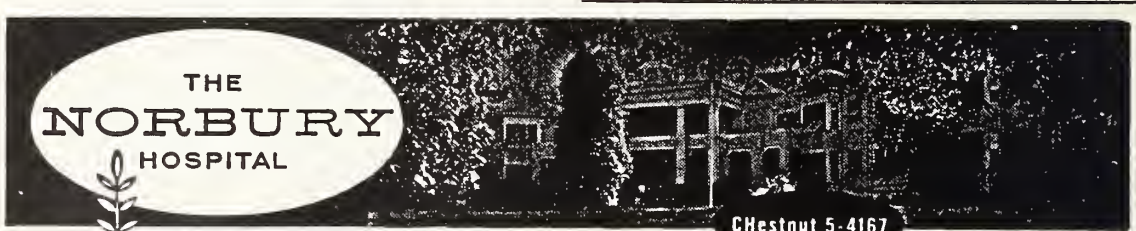
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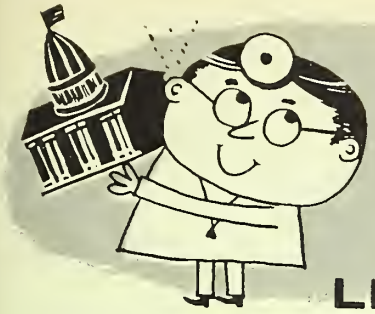


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LEGISLATIVE LISTENING POST

February, 1964

PRESIDENT INDICATES PRIORITY

In a February 1 televised news conference, the first on a scheduled basis since taking office, President Johnson declared high priority for Medical Care under Social Security. In response to a direct question on legislative priorities the President said,

"I do put Medical Care high on the list."

The President indicated that he wants the King-Anderson Bill brought out of the House Ways and Means Committee for a vote this year.

CMS BRANCHES VOTE FUNDS FOR LETTERS

Several Branch Societies of the Chicago Medical Society recently voted funds to generate letters to Congress against HR 3920. Under the plan, the individual physician prepares a letter to his patients asking them to write to their Congressman opposing HR 3920. Reproductions of the letter are arranged for through the Branch Society and returned to the doctor's secretary for personalized addressing and mailing. Branch Society funds are used to cover printing and mailing costs. Under an alternate plan members of the CMS Woman's Auxiliary do the addressing and mailing from the physician's patient list. Commenting on the plan, J. Ernest Breed, M. D., CMS Operation Hometown Chairman, said:

> "It is astonishing to see how many patients are eager to write their Congressman, when they know the facts about the King-Anderson Bill."

MEDICAL CORPORATIONS HAMPERED

Recent IRS rulings darken all hopes of physicians associated in professional corporations to gain equitable tax treatment on retirement contributions under so-called Kintner Plans. If adopted, these regulations would hold that a medical corporation, now legal under Illinois law, may not qualify as a corporation for Federal tax purposes because it is created to engage in a specific type of business. (See January IMJ article by Frank Pfeifer, ISMS Legal Counsel.)

Strong protests were lodged with Mortimer M. Caplin, Commissioner of IRS, in January, by ISMS, AMA, and kindred groups. A representative of ISMS will testify against the objectionable regulations on March 4 in Washington, D.C.

House Bill 9217 (Wiltner of Georgia) which would force IRS to allow medical corporations is being considered by the House Ways and Means Committee.

NEW INVESTIGATION COMING UP

The following is quoted from the February 3 issue of Washington Report on the Medical Sciences: "Prospects of a more spectacular investigation, covering collateral business practices of physicians, arose last week with an announcement by Sen. Philip A. Hart (D-Mich.). He heads the Senate antitrust subcommittee. Rising costs of health services, connections between physicians and pharmaceutical houses, compensation of hospital-based pathologists and radiologists -- these are among topics of this prospective inquiry. Sen. Hart spoke of "the proliferation of doctor-owned pharmacies" and continued:

"Where the doctor himself stands to profit from the sale of drugs which have the highest profit margin, it is unreasonable to expect that he would prescribe by generic names those drugs which would return him less profit."

AT LARGE ELECTION - STATE REPRESENTATIVES

The Illinois General Assembly, Tuesday night, January 28, passed an at-large election bill and adjourned the Special Session amidst charges of attempts to rig the election in favor of incumbent House Members. Agreement came after a final week of bitter squabbling and six and one-half hours of frantic last minute maneuvering. As finally passed, simultaneously nominating conventions will be held in Springfield June 1. Republicans and Democrats each must nominate the same number but not more than 118 candidates to run in November.

Controversy stems from a determination of House Members to limit the number of candidates to 100 thus assuring the election of most, if not all, incumbents. The current House makeup is 90 Republicans and 71 Democrats, 8 Democrats having resigned or died since the 1962 election.

Under the plan two delegates will be elected in the April 14 Primary from each of the 59 existing House Districts. Each delegate will be entitled to cast a weighted vote equal to one-half the number of votes cast for his party's House candidate or candidates in the last election. Candidates for delegates to the nominating convention must file petitions by February 6.

Independent candidates may enter the general election by filing petitions with the Secretary of State's office. Such petitions must contain at least 25,000 valid signatures with a minimum of 200 signatures from not less than 50 counties.

Cumulative voting will be abolished and special ballots and a special counting procedure will be used. The ballots will measure approximately 30 inches in length if all 118 candidates are nominated.

IMJ

Illinois Medical Journal

volume 125, no. 2 february, 1964

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By Robert L. Richards
Executive Administrator

How Tobacco Report May Affect the Physician

The American public was shocked into a new awareness of the smoking peril when the surgeon general's committee reported that the use of tobacco has now been definitely established as a health hazard. The cold, hard statistics contained in the report, however, only served to prove what most physicians had been claiming for quite some time—that smoking often represents the major predisposing factor in the development of various disease conditions.

Now the public wants to know the truth about how and why the use of tobacco can impair health and cause disease. To satisfy this public demand for pertinent information, the administration has directed the U.S. Public Health Service to launch the greatest "saturation" propaganda campaign ever undertaken by a government agency. Copies of the surgeon general's committee report are being sent to all physicians, osteopaths, medical and dental societies, major health organizations, members of Congress, U.S. embassies abroad, and foreign embassies in this country.

As yet, however, this ambitious "saturation" campaign has not officially provided any means for making anti-smoking education material available to the persons who need it most—John and Jane Public. Who, then, will bear the brunt of telling the people what they want to know about the tobacco-disease relationship? The physician, of course!

Thus it is reasonable to assume that many a physician will be called upon to lecture a civic, fraternal, religious, or business group about the dangers of smoking. And many a physician will certainly be invited to discuss teen-age smoking habits with PTA groups, assemblies of high school students, and other organizations concerned with youth welfare.

All of this means that the physician will now be forced to devote much more of his time to extra-professional educational activities. The *Journal* editorial staff considered this time-consuming factor very seriously when it set out to plan this issue. We would therefore like to point out three specific articles which the physician may use as time-saving devices:

1. The article, *Inflammatory Change Associated with Neoplasm: A Pitfall in the Roentgenologic Diagnosis of Pulmonary Carcinoma,* by Dr. Myron Melamed and Dr. Leonard Berlin, is illustrated by several excellent photographs of lung carcinoma. We arranged many of these photographs on one page in order that a physician might have a handy "teaching aid" which he might use to explain what lung cancer is to patients or to the public.

2. *The Tobacco Problem* was written by our editor, Dr. T. R. Van Dellen—not by some gossip-columnist turned crusader. This article might prove useful to the physician who is called upon to advise a patient or a group on the best ways to stop smoking.

3. *Teen-Age Smoking Habits* is an authoritative statistical study of smoking habits among teen-agers. It was conducted by Gilbert Youth Research, a reputable and dependable organization which specializes in the study of teen-age behavior. The statistics contained in this study might well provide the "meat" for a talk that the physician is called upon to make before groups interested in the welfare of the teen-agers.

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Abstracts of Board Actions

Meeting of January 11-12, 1964

PUBLIC AFFAIRS COMMITTEE FORMED

The Board approved formation of a Committee on Public Affairs, whose basic function will be to stimulate active participation in public activities by Illinois physicians and their wives. Specific duties include establishment of Public Affairs Committees at the county level and the publication of a bi-monthly newsletter to keep the entire membership and Auxiliary up-dated on public issues. Chairman of the new 24-member committee is Dr. John A. Newkirk, Elgin, former chairman of the Illinois Medical Political Action Committee.

SMOKING RESOLUTIONS PASSED

A Resolution on teen-age smoking—calling for an agressive and continuing program designed to prevent children from starting to smoke and to influence teen-agers who are smokers to discontinue the habit—was submitted by the Child Health Committee and passed by the Board. The Resolution added that "these policies should be made known to all physicians and residents of Illinois by appropriate means."

ENVIRONMENTAL HEALTH CENTER PROPOSED

President Elect Dr. E. A. Piszczek proposed the possibility of establishing an Environmental Health Center—such as the one described by the United States Public Health Service—in Chicago. He said that the deans of the medical schools and engineering colleges in the Chicago area were currently drawing up a "white paper" presenting the advantages of Chicago as the site for such a Center.

IMMUNIZATION OF CITY AND COUNTY EMPLOYEES OFFERED

Dr. Franklin D. Yoder, Director, Illinois Department of Public Health, reported that the Department would furnish sera for immunization of city and county employees if the local medical society and the Board approved. The Board suggested that each county medical society be contacted in this regard to see if such a program should be instituted.

ILLINOIS ASSOCIATION OF THE PROFESSIONS ORGANIZED

Dr. George B. Callahan, ISMS Delegate to the Association of the Professions and current Chairman of the Association, announced that formal election of officers will take place at the next meeting March 19. All seven professional groups comprising the Association have made financial commitments and their individual representatives are paying personal dues.

COMMITTEE ON AGING REPORT

Chairman Dr. E. W. Cannady reported that the Committee plans distribution of a guide for use by district and court Committees on Aging to assist in the implementation of programs. After distribution, meetings will be scheduled with each district committee to discuss the program and urge immediate implementation.

If the request for a community health services grant is approved, the Chicago Educational Television Association will develop six programs under the title: "Demonstration of the Use of Television as a medium of Education in the Home Care of the Chronically ill and disabled." Dr. Edward Gordon will serve as co-director of the proposed project and Dr. Cannady will serve on the Advisory Council. Video tapes of the programs will be made available to other TV stations.

All nursing homes will be urged to request "accreditation" voluntarily, under a new accreditation program of the National Council of Nursing Home Accreditation.

Short orientation courses for physicians in rehabilitation may be offered by the Department of Public Health.

(continued on page 122)

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(continued from page 120)

PLAN TO EXPEDITE PUBLIC AID DISABILITY DETERMINATIONS

The Advisory Committee to the Department of Public Aid announced that disability determinations will now be forwarded to a medical review team under the direction of Dr. Wasserman at the Department. This action will bypass county advisory committees—where some decisions have been delayed—and thus expedite processing.

NEW PR SUBCOMMITTEE APPOINTED

Because of the tremendous increase in radio and TV activity by the Public Relations Committee—resulting in a total of 110 hours of public service broadcasting in 1963—a new Subcommittee on Radio and TV has been formed. Chairman is Dr. Leo P. A. Sweeney, who is also Chairman of the PR Committee. Members of the subcommittee are currently being appointed.

WHITE PAPER ON DRIVER LEGISLATION PREPARED

Dr. Julius M. Kowalski, Chairman of the Public Safety Committee, reported that his committee currently is drawing up a "White Paper" on driver legislation. Upon its completion the Committee will meet with the ISMS Legislative Committee to cooperate in every way possible in developing good licensing laws for Illinois drivers.

CHANGES IN CONSTITUTION AND BYLAWS TO BE PUBLISHED

Dr. Andrew J. Brislen, Chairman of the Committee on Constitution and Bylaws, announced that changes recommended at the Committee meeting January 10 will be reported to the Board in March and subsequently published in the Illinois Medical Journal for the information of the entire membership.

DATE FOR SECRETARIES' CONFERENCE ANNOUNCED

Secretary-Treasurer Dr. Jacob E. Reisch announced that the Secretaries' Conference for 1964 would be held Sunday, April 14 at the St. Nicolas Hotel in Springfield. The secretaries' opinions on the new system of individual billing will be solicited. For the first time, presidents-elect of all county medical societies have been invited.

HOSPITAL DISASTER FILM PLANNED

Dr. Max Klinghoffer, Chairman of the Disaster Medical Care Committee, reported the possible production of a film to train physicians and allied medical personnel in the basic outlines of a hospital disaster program. The film would be available for showing on TV stations throughout the state.

REPORT OF THE PRESIDENT

Dr. Harlan English, ISMS President, indicated that the House of Delegates will be called upon to develop a policy for birth control to serve as a guide for the Society.

He also reported that a survey of medical education facilities throughout the state will be conducted under the auspices of the University of Illinois. Such a survey may possibly indicate the location of new medical centers, facilities and medical schools.

BENEVOLENCE COMMITTEE REQUESTS ADDED FUNDS

Two requests referred to the Finance Committe were (1) that $5.00 per membership be allocated to Benevolence until the reserve fund reaches $300,000—enough to meet needs if current demand remains the same—and (2) that the committee be permitted to solicit contributions from retired and emeritus members.

ENLIST COOPERATION OF LABORATORIES AND BLOOD BANKS

To prevent unnecessary discipline and maintain the philosophy of professional surveillance, the ISMS Laboratory Evaluation Committee urged county medical societies to be familiar with the clinical laboratories and blood banks in their areas and encourage them to register with the state.

IMJ

Illinois Medical Journal

volume 125, number 2 february, 1964

Inflammatory Change Associated with Neoplasm: A Pitfall in the Roentgenologic Diagnosis of Pulmonary Carcinoma

Myron Melamed, M.D., and Leonard Berlin, M.D.

The typical roentgenologic signs of carcinoma of the lung are well known to all clinicians. Meschan[2] recently summarized the characteristic roentgen findings of bronchogenic carcinoma, and listed them as follows:

1. A *hilar mass,* sometimes associated either with atelectasis or with obstructive emphysema.
2. A *peripheral mass,* solid, cavitary or pneumonic in type.
3. *Diffuse lymphangitic infiltrations.*

The same author also classified the appearance of metastatic lung tumors, placing them into these categories:

1. *Miliary*
2. *"Golfball" tumor masses.*
3. *Pleural,* manifested either by solid tumor or fluid accumulation.

Since most pulmonary carcinomas fall into one of the above categories, a correct presumptive diagnosis can frequently be made on the basis of the chest roentgenogram only.

As a rule, once a carcinoma causes a roentgenographic abnormality, this abnormality persists and usually becomes more extensive as the malignant growth flourishes. This observation serves as the basis for the "progress film," which is sometimes ordered when one is confronted with a chest roentgenogram that is suspicious of, but not diagnostic of, carcinoma. Since an untreated malignant tumor usually proceeds without delay in an unrelenting and downhill course leading to death of the patient,[3,4] a progress study showing enlargement of the suspicious lesion most frequently indicates a malignant growth. Conversely, a significant improvement without specific anti-cancer therapy almost certainly points to a benign lesion. While this rule is valid in almost all instances, *there is a situation where it does not apply*—when there is a presence of significant "peri-tumorous" infiltration.

Peri-tumorous Infiltration

"Peri-tumorous infiltration" is used here to in-

From the Departments of Radiology, Grant Hospital of Chicago, Chicago, Illinois; and the University of Illinois College of Medicine, Chicago, Illinois.

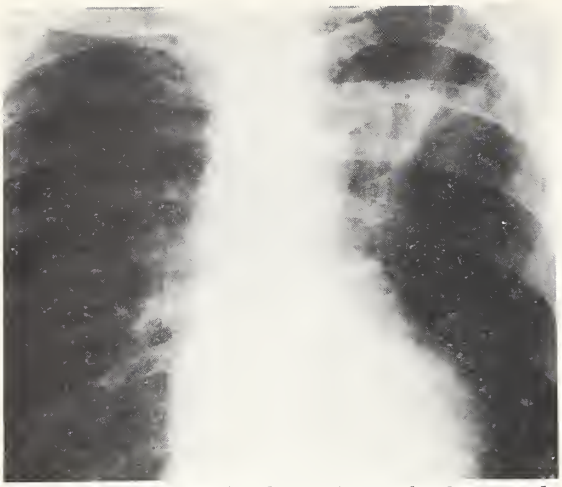


Fig. 1. Case 1. Initial radiographic study showing abnormal opacity in region of anterior segment of left upper lobe.

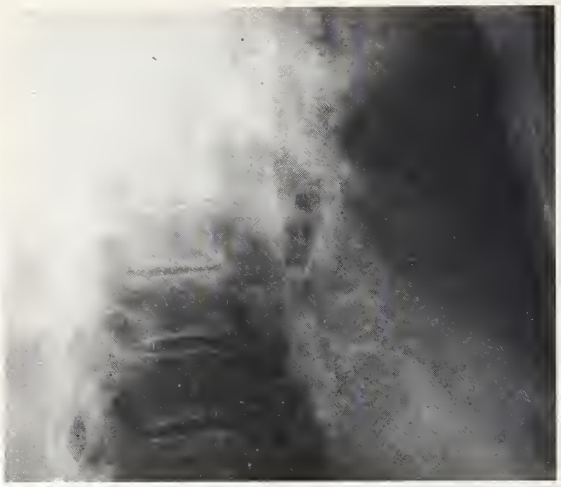


Fig. 2. Case 1. Lateral view of same study.

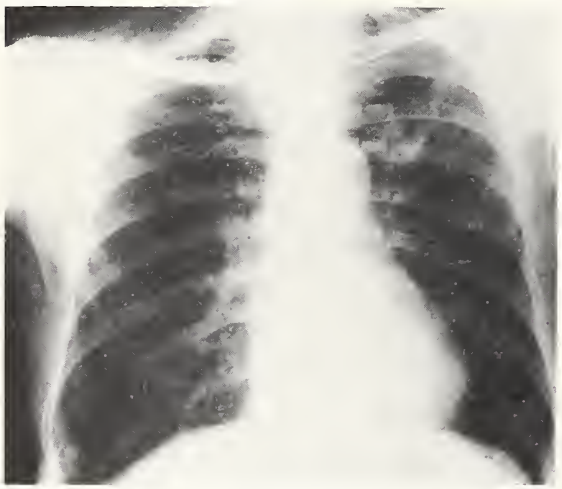


Fig. 3. Case 1. Progress film taken two weeks later. Definite improvement in lesion. Subsequent thoracotomy disclosed carcinoma of the left upper lobe.

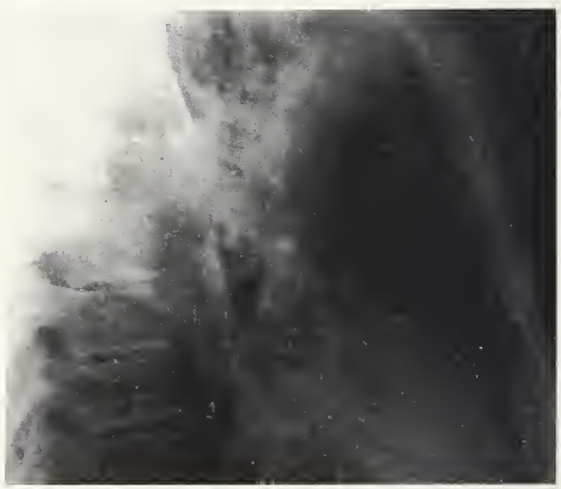


Fig. 4. Case 1. Lateral view of same case .

clude such pathological phenomena as atelectasis, pneumonia, hemorrhage and infarction which anatomically surround, and may be secondary to, carcinoma. Roentgen rays make no differentiation between tumor cells, inflammatory cells, and exudate. On a roentgenogram, an inflammatory or atalectatic component can blend with an actual tumor to produce a shadow that is much larger in size than the carcinoma itself. If antibiotic or other supportive therapy resolves the secondary changes, the radiographic abnormality will improve considerably, although the tumor itself will be unchanged. This improvement in appearance may well mislead the clinician into believing that he is dealing with a benign condition. Some cases of "spontaneous tumor regression" are undoubtedly related to resolution of secondary processes.

The following cases are presented to illustrate this pitfall in the diagnosis of pulmonary malignancy:

Case 1

A. S., a 75 year old white male, was admitted to Grant Hospital of Chicago on May 29, 1955, for a left exploratory thoracotomy. On April 14 of the same year, a chest radiograph (Figs. 1 and 2, Case 1) revealed an abnormal opacity in the region of the anterior segment of the left upper lobe. The patient denied any pulmonary symptoms. Radiographs had been done as a routine procedure prior to radiation therapy for a basal cell carcinoma of the skin of the face. The pa-

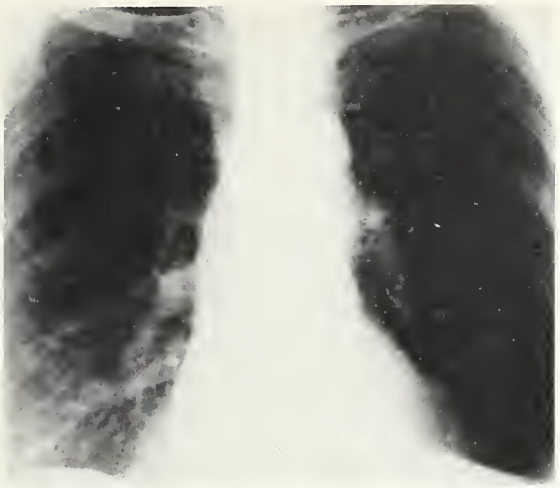


Fig. 5. Case 2. Initial radiograph showing only left pleural effusion. No nodule is seen.

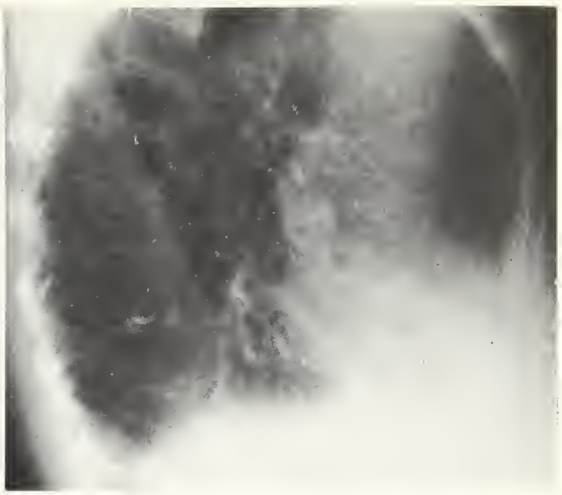


Fig. 6. Case 2. Lateral view of the same ease.



Fig. 7. Case 2. Four weeks later. A nodule, 4.2 eubic eentimeters in volume, ean be seen in left lower lobe.

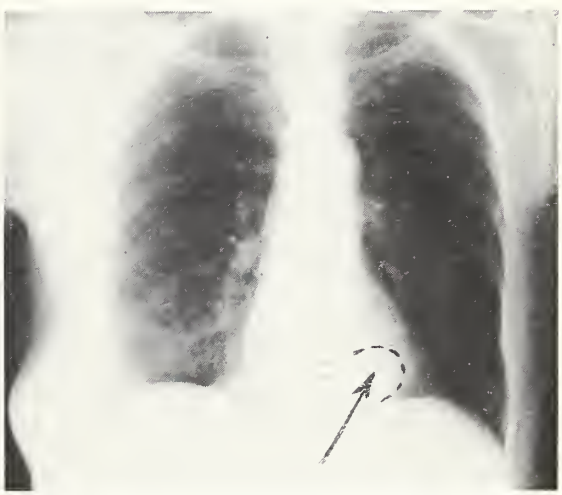


Fig. 8. Case 2. Six months later. Enlarged left lower lobe nodule now has a 33.5 cubie centimeter volume.



Fig. 9. Case 2. After three months, nodule volume reduced to 5.6 eubic centimeters. Surgery eonfirmed metastatie tumor.



Fig. 10. Case 2. Lateral view of same ease.

tient was treated with streptomycin and achromycin.

Roentgenograms on April 29, 1955 (Figs. 3 and 4, Case 1) revealed definite improvement in the lesion. Bronchoscopy and sputum studies were done but revealed no abnormalities. Physical examination and laboratory tests were non-contributory.

Roentgenographic examination on May 30, 1955 showed no further improvement. For this reason, a left thoracotomy with pneumonectomy was performed on the following day. Pathologic examination of the left lung revealed an epidermoid carcinoma arising in the main bronchus to the upper lobe. The anterior, and to a lesser extent, the apical-posterior segmental bronchi were markedly dilated and contained purulent material. Regional lymph nodes showed no evidence of tumor.

At present the patient is living and free of apparent disease.

Case 2

T. M., a 69 year old white female, was admitted to Grant Hospital of Chicago on December 27, 1959, for left thoracotomy and excision of metastatic skin nodules. In December, 1947, a left radical mastectomy had been performed for scirrhous carcinoma of the left breast. Three subsequent admissions from March, 1954 to October, 1957 occurred. During these periods local resections of metastases to the surgical scar and chest wall were performed.

Chest radiographs taken March 9, 1959 (Figs. 5 and 6, Case 2) disclosed fluid in the base of the left pleural cavity. Spontaneous resolution of the fluid occurred. On roentgenographic examination of April 4, 1959 (Fig. 7), a nodule having a volume of 4.2 cubic centimeters became visible in the left lower lobe. No therapy was instituted. The nodule enlarged. In September, 1959, the patient developed hemoptysis. Radiographs taken on October 1, 1959 (Fig. 8), revealed considerable increase in size of the nodule at the left base. This nodule had a volume of 33.5 cubic centimeters.

The patient received no hormonal or other anticancer therapy. Subsequent radiographs showed the nodule in the left lower lobe to diminish in size. Examination of December 28, 1959 (Figs. 9 and 10, Case 2), revealed a volume measurement of 5.6 cubic centimeters, or one-sixth the volume it had three months earlier.

Partial lobectomy of the left lower lobe, along with resection of several skin nodules, was performed on December 29, 1959, without complication. Pathologic examination of the lung tissue revealed a nodule of metastatic breast carcinoma. Portions of the tumor were necrosed and were surrounded by organizing inflammatory tissue.

The patient has subsequently developed evidence of disseminated metastatic disease.

Discussion

In both of these cases, solitary pulmonary lesions demonstrated roentgenographically showed significant decrease in size over a period of time, yet subsequently were proven to represent carcinoma. Histological examination of the surgical specimens, however, revealed inflammatory and necrotic changes surrounding the carcinomatous lesions. It was assumed that the original abnormalities demonstrated on the roentgenograms represented secondary pathological changes in addition to the actual tumors, and that it was these secondary abnormalities—and not the cancer cells themselves—which decreased in size prior to surgery.

This condition of "peri-tumorous infiltration" is one of utmost importance to the clinician and to the radiologist if an early diagnosis of cancer is to be achieved. It should always be remembered when "progress" radiographs are interpreted. Felson[1] says that all pulmonary infiltrations should be followed to complete roentgent clearing. In this way many early lung carcinomas will be diagnosed.

Summary

We have presented two cases of pulmonary lesions in which the abnormal roentgen shadows decreased significantly in size over a period of time, yet were subsequently shown to represent carcinoma. Surgical specimens revealed inflammatory and necrotic tissue surrounding the tumors. It is therefore presumed that adjacent inflammatory components, rather than the tumors themselves, underwent partial resolution. This phenomenon of "peri-tumorous" infiltration is a pitfall in the roentgenologic diagnosis of pulmonary carcinoma; an awareness of its presence is essential if diagnosis of early lung cancer is to be made.

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The Tobacco Problem

T. R. Van Dellen, M.D.

The relationship between excessive cigarette smoking and certain cardiorespiratory diseases is well established in the minds of many physicians and voluntary health groups. Many warnings have been publicized during the past 10 years with little or no effect on the consumption of cigarettes. If anything, these warnings have popularized filters and created so much confusion that the medical profession is losing face with the laity.

This is an ironical situation considering the current activities of the FDA and Congress in their fight against potentially dangerous drugs and food products containing carcinogenic substances. The American people also profess to be vitally interested in their health, yet spend *almost as much money** on tobacco and alcohol as on physicians, drugs and hospitalization combined. It is true that many adults have stopped smoking, but the sales of cigarettes in the United States last year reached an all time high of one half trillion—an increase of one hundred billion more than were sold in 1953 (the year that lung cancer was linked to tobacco). Much of this increase in per capita consumption is attributed to the number of teen-agers who smoke. It was found in one study that 14 per cent of high school freshman and 22 per cent of juniors were smokers. This is one of the reasons why many anti-smoking campaigns are aimed at the teen-ager, hoping to discourage the boy or girl from starting. It is better to avoid or defer cigarette smoking as long as possible since it is difficult to break the habit once it is well established. New York City's Bureau of Public Health Education, the American Heart Association and other groups have programs to deter school children and teen-agers from smoking. While we mark time, some 4,500 boys and girls between the ages of 12 and 17 take up smoking each day of the year.

*Tobacco	$ 6.3 billion	Medical Care—
Alcohol	$ 9.2 billion	$16.7 billion
	$15.5 billion	

Programs of this nature are handicapped by advertising in which smoking is portrayed as a desirable and pleasurable habit of sophisticated and successful people. The advertising appeals also to manliness, features youth's heroes, presents romantic situations and gives the impression that smoking is an essential part of modern life. According to *Changing Times*, L. W. Bruff, vice president of Liggett & Myers Tobacco Company said: "Between the time a kid is 18 and 21, he's going to make the basic decision to smoke or not to smoke. If he smokes we want to get him." Starting to smoke early in life is most objectionable because time and consumption play an important role in causing disease. Those who start early tend to smoke more, and over a longer period of time.

Anti-tobacco crusades have been going on for 300 years. According to Joe R. Williams, Chief of the Tobacco Division of the Agriculture Department's marketing services, attacks on tobacco "usually end up by stimulating consumption." The role of this government employee is to help tobacco farmers sell their leaf. The story of our public guardians is covered in a new book *Smoke Screen* by United States Senator Maurine B. Neuberger (Prentice Hall). Those interested in the Government's role in the smoking problem should read this book. It may be of interest to know that tobacco was first combatted in Europe during the mid 1500's by both the Church and the State as an enslaving addiction. The opposition ceased when Richelieu in France, and Charles I in England, discovered the possibilities of tobacco as a source of tax revenue. Anti-smokers today are bucking an 8 billion dollar industry and 70 million smokers whose slogan is "Statistics never killed anyone."

Smoking and Cancer

Statistics may not mean anything to many people but those closest to the problem understand them and are concerned. The stand taken by the American Cancer Society is well known. They continue to find a close relationship between cigarette smoking and lung cancer, and the risk of developing the disease is directly related to the number of cigarettes smoked. They report that lung cancer now kills about

41,000 Americans per year. The rate is now 10 times what it was 30 years ago.*

Cigarette smokers also have higher death rates from chronic bronchitis and emphysema. The death rates from these conditions also are on the inerease. Precancerous changes are consistently found in cells lining the bronchial tubes of cigarette smokers who died of causes other than lung cancer. Smoke also eontains tars carcinogenic to mice and other agents (co-carcinogens) that enhance the cancer-producing ability of certain carcinogens. Air pollution also enters the picture and since the cigarette is concentrated air polution it cannot be disregarded from this point of view. Cigarettes also contribute indirectly to the death rate from cancer of the lung. They are the cause of smokers bronchitis which masks the early symptoms of bronchogenic carcinoma.

Smoking and Cardiovascular Diseases

The American Heart Association's ad hoc Committee on Smoking and Cardiovascular Diseases again found a statistical association between heavy cigarette smoking and increased mortality and morbidity from coronary artery disease. Death rates from coronary heart disease in middle-aged men were found to be from 50 to 150 per cent higher among heavy cigarette smokers than among those who do not smoke.

The Committee also reeommended that physicians encourage *all* patients to stop smoking, especially patients "who have a high risk of death and illness from coronary artery disease and myocardial infarction, namely those with high blood pressure, high blood cholesterol levels, overt signs of hardening of the arteries, a family history of heart attacks and strokes in middle age, or a combination of any of these." Meanwhile cigarette manufacturers, or more specifically, spokesmen for the Tobacco Industry Research Committee come back with "nothing has been proved" and many other unsupported denials.

The physiological effects of nicotine on the heart are well known. It acts indirectly by stimulating sympathetic ganglia, raising blood pressure, and increasing the production of catecholamines from the medulla. The latter dilates the coronary arteries. Nicotine acts directly by increasing the heart rate, cardiac output and stroke volume. This may be fine for the person with a normal heart, but not for those with arteriosclerotic heart disease. The inerease in activity by the heart is not accompanied with dilatation of the thickened coronary arteries. This leads to deficient vasodilatation, the cause of tobacco angina—an uneommon condition.

The relationship between thromboangiitis obliterans and smoking is well known. It plays a minor role in Raynaud's disease in that to stop smoking has little or no effect on preventing attacks. Toxie amblyopia also is a recognized condition and many physicians recommend less or no smoking for those with peptic ulcer.

Advising Patients About Smoking

The conditions cited above are mentioned because they provide ammunition when it comes to discouraging teen-agers from smoking. Such information ean also be used to motivate the heavy smoker who would like to quit. "How can I quit smoking?" is now the question many physicians are being asked, particularly since the report of the advisory committee to the United States surgeon general was brought to public attention.

There is no known drug or combination of drugs that can cure or overcome the tobacco habit, or permanently eliminate the desire for tobacco. It takes simple determination, backed up by will power to stop. This is *easier to do* when there is strong motivation. There is no doubt that eigarette smoking may be harmful for certain persons and the more this point is hammered home, the better the chance for success. This is *easier to accomplish* when the physician believes in moderation and recommends no smoking only when absolutely neeessary. In addition, it must be recognized that smokers and nonsmokers have different habits. The smoker is more neurotic, marries more often, changes jobs and moves more frequently. We might as well face it, when it comes to the hardened smoker—some are difficult to change, and it takes every trick in the book to do it.

*Pathological studies show that men who smoke less than ½ pack a day have 15 times the lung cancer mortality rate of non-smokers. Heavy smokers 64 times.

Others find it easy to quit. Smoking may in this respect resemble drinking—some tobaccics are firmly hooked.

Determination to quit also is fostered through religion or group therapy. One organization (Seventh Day Adventists) has had good results with a 5-day plan including diet, exercise, prayer, and stressing will power. During this time the individual consumes mainly prunes, fruit juices, cereals, milk, vegetables, and nuts. Stimulants such as coffee, tea, cokes and alcohol are not allowed.

There are several tobacco withdrawal clinics in Europe. Group discussions center about smoking patterns, psychology of smoking, effects of nicotine on the body and related topics.

But despite these well meaning plans, smoking like other habits, is difficult to curb. There is a continual desire to smoke during the first few days of abstinence. Smoking provides oral satisfaction which is missed during the first week of abstinence. This is the basis for recommending gum, mints and lozenges. The individual becomes irritable and yearns for something to hold in the hands or mouth. This role of the fingers and hands is a part of the habit and is difficult to overcome, especially when driving the car, playing cards, or at work. One convert put it this way: "Your reflexes must be untrained from reaching for a cigarette just as you might untrain yourself from the habit of scratching your head or tweeking your nose.

Lobeline Preparations

Many preparations have been introduced as deterrents to smoking. These crutches help some persons forego the tobacco habit, especially individuals amenable to suggestion. More than 25 years ago we used lobeline sulfate at the vascular clinic of the former New York Postgraduate Medical School and Hospital. This product was once used like tobacco by the American Indians. It is a powerful and dangerous emetic when ingested in large doses. We used the product because of the similarity in action with nicotine. In addition, a cross tolerance between the two develops.

The use of lobeline was discontinued because too many of our patients with peripheral vascular disease developed epigastric distress. More recently, Dr. C. W. Rapp, Ph.D., of Loyola University School of Dentistry, Chicago, Illinois, combined lobeline sulfate with an antacid (Bantron). According to Dr. Rapp, Bantron succeeded in reducing the number of cigarettes smoked from an average of 18 to 4.6 per day. Of the subjects who wanted to quit, four out of five were able to do so within five or six days. This study has not been confirmed and we have no followup to report as to whether these smokers returned to their previous habits.

It was interesting to note that lobeline hydrochloride was used in Swedish tobacco withdrawal clinics. Approximately 76 per cent of 1,012 patients stopped smoking and 21.7 per cent reduced the intake. Of those who stopped, 50 per cent maintained good results.

The use of lobeline compounds or similar products probably aids when a "crutch" is needed. The most effective control takes place when the physician is thoroughly convinced that smoking is harmful and cautions his patients to abstain. This supplies the strongest motivation. Others will require supports similar to those given the drunkard by Alcoholics Anonymous. I always tell my patients that one puff and they will be smokers again.

Weight Gain After Abstaining

The increased sensation of hunger along with weight gain are troublesome side effects that follow giving up the habit. There may be a physiological reason for this beyond the increase in appetite. At any rate, it is one of the major deterrents to any suggestion to stop smoking. The vicious circle that follows is well known: stop smoking, increase appetite, increase food consumption, five to ten extra pounds, then resumption of smoking to curb appetite. Anticholinergic drugs and tranquilizers are said to help.

Relapses also occur during cocktail parties and periods of unexpected stress such as a death in the family or financial reverse.

Summary and Opinion

In my opinion, any fight against smoking should start at the grass roots level. County

and state medical societies must take unequivocal positions and actions in this dispute. In this regard they must follow the lead of the American Cancer Society and the American Heart Association. The evidence that incriminates smoking is so overwhelming that it is the duty of the medical profession to bring the hazard to the attention of the people. We must also help our government to clear away the highly emotional air surrounding the puzzle. The fight should go beyond the education of the teen-ager and discouraging the adult to stop smoking. We should insist on more research into the technology of safer smoking. Meanwhile, there should be reforms in cigarette advertising and promotion.

Cigarette Smoking Habits of Teen-agers

The prevalence of cigarette smoking among the nation's teen-agers is a major concern to everyone who is interested in youth welfare. Quite naturally, there is a heavy demand for factual, qualified information about the cigarette smoking habits of our young people. Until recently, however, few authoritative, statistical analyses of the teen-age smoking problem had been published.

In 1963 a comprehensive study of teen-age smoking habits was undertaken by *Gilbert Youth Research*—a reputable organization which specializes in collecting and interpreting data that is particularly related to the activities of teenagers. The Gilbert Study was based on personal interviews with about 2,000 youngsters, all of whom were in the 13-to-18-year-old bracket. The entire U.S. teen-age population was represented in this sample.

Here, then, are some of the results obtained by the Gilbert Study:

Why Teen-Agers Smoke

More parents of teen-age smokers use cigarettes than do the mothers and fathers of youngsters who do not smoke. This fact is substantiated by American Cancer Society studies. Apparently, therefore, *parents' smoking is directly related to smoking by their children.*

About 60 per cent of all teen-age smokers have their parents' permission to do so. Parents seem more inclined to grant permission to smoke to older teen-agers. Thus, 70 per cent of all 17-year-old smokers, and 80 per cent of the 18-year-olds, have their parents' consent.

Approximately half of the teen-age smokers cannot explain *why* they began to smoke. Some 13.2 per cent admit they are influenced by examples set by friends.

Some Smoking Habits of Teen-Agers

About 71 per cent of the entire teen-age population does *not* smoke. Less than 15 per cent of the 13 and 14-year-olds smoke.

The study indicates that cigarette smoking increases with age among teen-agers. About 22 per cent of all teen-age smokers are 15-year-olds, 27 per cent are 16-year-olds, and 47 per cent are 18 years old.

The average teen-age smoker consumes *less* than four packages of cigarettes per week. About 57 per cent of teen-age smokers use less than three packages per week.

How and Where Teen-Agers Get Cigarettes

Of all teen-agers polled—including smokers *and* non-smokers—74.6 per cent do not purchase cigarettes at all. More than 70 per cent of teen-age smokers *buy* their cigarettes. *Friends and family provide cigarettes for more than one fourth (27.8 per cent) of all teen-age smokers.*

More than 7 out of 10 (73.1 per cent) of all teen-age smokers buy cigarettes *over the counter.* 52.1 per cent of these buy cigarettes in drug stores, 13.9 per cent in supermarkets, and 12.8 per cent in small food stores. About 4.5 per cent obtain cigarettes from vending machines.

Surgical Repair of Otosclerosis

Jules Kaplan,* M.Sc., M.D.

Otosclerosis is the most common cause of hearing loss in young and middle-aged adults.[1] It tends to run in families and is slightly more frequent in females. About half of pregnant women with otosclerosis suffer a dimunition of hearing during, or shortly after, their pregnancy.

In about 85 per cent of the cases, otosclerosis causes a gradual conductive hearing loss, which usually begins in one ear, but eventually affects both ears. It is rare under the age of 12, but is found in all other age groups.

Diagnosis

The diagnosis of otosclerosis is not difficult to make. The only necessary equipment includes a 256 tuning fork and an otoscope. A complete history is, of course, mandatory.

A patient who complains of a hearing loss but who has a clear, intact eardrum, and who hears the vibrating 256 tuning fork better on the mastoid than in front of the auricle, has a conductive hearing loss which may fall into one of the following categories:

1. anomaly of the ossicular chain
2. fluid in the middle ear
3. adhesive otitis media
4. dislocated incudostapedial joint
5. otosclerosis

Each of the conditions listed above is reparable by surgery. With the exception of adhesive otitis media, each has a high rate of success. If the patient presents no history of frequent otitis media, no traumatic history or loss of hearing since early childhood, and if the drum is of a normal pearl color with its usual landmarks, the diagnosis is probably otosclerosis. If followed long enough, the hearing loss will be progressive.

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Pre-Surgical Information and Preparation

The surgeon will have audiometric information of the level of hearing by air and bone. He will also know about the patient's ability to distinguish words at a loud intensity (discrimination score). If there is a conductive loss of 25 decibels or more, and if the discrimination score is good, the patient is a good candidate for stapes surgery. There are few contraindications for this surgery. It has been successfully performed on patients in their teens and on nonagenarians. The patient must be on his back. His head should be turned to one side—with the side to be operated on directed upward—for 60 to 90 minutes. If there is no spinal pathology to prevent this, the patient can probably tolerate the surgery. Premedication is usually no more than 100 mg. of a short-acting barbiturate.

The anesthetic is local. Usually one tenth of one cc of 1/1000 adrenalin in 2cc of xylocaine is sufficient for deep anesthesia of the ear canal, eardrum, and middle ear.

Surgery

The surgery is performed by elevating a flap of canal skin along with the eardrum, thus exposing the middle ear. One to two mm. of bony canal rim may be removed to facilitate exposure.

There are two major schools of thought regarding the surgical handling of the otosclerotic stapes. One group of otologists believes in total removal of the stapes and replacement by prosthesis in every case. This procedure is called *total stapedectomy*. The other group believes in the *graduated by-pass* technique, which fits the surgery to the pathology.

The principles of surgery for otosclerosis are uniform in both techniques. In either situation, the surgeon must create a mobile sound pressure transformer (the large eardrum must be connected by a chain of bones or a single

columella to a small mobile oval window covering). He must bear in mind that breaking through an otosclerotic focus tends to cause that area to reactivate, or refix. He must exercise extreme care to avoid damaging the membranous cochlea.

Stapedectomists feel that leaving otosclerosis behind, or inadvertantly breaking through an otosclerotic focus, predisposes toward refixation of the footplate in a significant percentage of cases. They further feel that development of a standard technique promotes facility in surgery. The more conservative graduated by-pass group, who suit the surgery to the lesion, hold a somewhat different opinion. They claim that 25-55 per cent[2] of all otosclerosis is an anterior lesion only. They say that this type of lesion responds well to anterior cruratomy and footplate fracture, to partial stapedectomy, or to mobilization of a normal fragment of the footplate connected to the incus by means of a polyethylene prosthesis. This group feels that removal of the footplate opens the labyrinth widely and increases the risk of cochlear damage.

Results of Surgery

Both groups agree that when total obliterative otosclerosis is present the results of surgery are not as satisfactory as they are in other types of otosclerosis, and that the incidence of cochlear damage is quite high. When a totally involved footplate (with margins obliterated by otosclerosis) is encountered, some surgeons have suggested closing the ear and recommending either a hearing aid or the old fenestration operation. Fortunately, obliterative otosclerosis is rare, composing only 2-5 per cent of all cases.

Both groups have successful results ranging from 85 to 90 per cent. Only about 1 to 4 per cent of ears were made worse by surgery.[3] The fact of the matter is that the methods of an individual surgeon are probably based upon personal preference, and that the technique a particular surgeon is most comfortable with will probably produce the best results for him. This is equally true of the materials he uses for prosthetics.

Post-Operative Factors

About 90-95 per cent of patients are able to go home the day after surgery. There may be some post-operative vertigo, especially following total stapedectomy, but almost all patients leave the hospital by the second day after surgery.

Silk-strip cotton packing placed into the ear occludes the ear canal and obliterates the hearing. This is removed in 5 to 7 days after surgery. Some patients hear well immediately thereafter. The hearing acuity of others increases gradually over a period of a month. If there is no hearing improvement within a month's time, the surgery may be considered unsuccessful. Such a situation should be re-evaluated for possible additional surgery if a *conductive* hearing loss remains.

At least three months should elapse before reasonable certainty of permanent hearing gain can be assumed in successful stapes surgery patients. If the patient has maintained his hearing improvement for a year after surgery, the chances are probably 99 out of 100 that it will be a permanent hearing gain.

Summary

Stapes surgery has become a very successful method for treating otosclerosis. Because of its low morbidity and high success rates, it can be recommended with confidence.

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ISMS Annual Convention May 17-21

Wednesday Is Chicago Doctor's Day!

The View Box

LEON LOVE, M.D.
Director, Diagnostic Radiology
Cook County Hospital
Chicago, Illinois



Film 1



Film 2

This 10 year old Negro boy complained of poor appetite, diarrhea, and cramping abdominal pains.

Physical examination revealed a poorly nourished child with pale conjunctivae.

Laboratory work-up revealed: Red blood cells 3 million, hemoglobin 8 grams, and 12 per cent eosinophiles.

What is your diagnosis?

1) Peutz-Jeghers Syndrome
2) Hodgkins of small intestine
3) Regional enteritis
4) Ascariasis of the intestine

(Continued on page 163)

Bacterial Meningitis in the Elderly

Michael M. DiGilio, M.D.*

The purpose of this paper is to present two cases of bacterial meningitis in elderly subjects, neither of whom displayed the typical physical findings of meningeal irritation such as nuchal rigidity, or Kernig's or Brudzinski's signs. A review of standard text-books of medicine[1-3] and of the English literature for the last ten years did not reveal a description of this phenomenon.

Paterson and Hamilton[4] noted that the classical features by which meningitis is recognized are often inconspicuous or absent in infants. They observed that increased tension or bulging of the fontanelles in the well hydrated infant, as well as drowsiness alternating with irritability, high-pitched cry, a vacant look in the eyes or the development of squint are possibly the most valuable signs. None of these signs are applicable to—nor were observed—in these elderly patients. However, the lack of so-called localizing meningeal signs was similar in this group as the one at the opposite end of the "age spectrum."

Case No. I 59-2587

A 64 year old white male priest-missionary, recently returned from the Belgian Congo, was admitted to the hospital on March 13, 1959. He had a past history of malaria and complained of diarrhea and vomiting. Little other history could be obtained because the patient was disoriented. The temperature was 103°. The spleen was thought by one observer to be palpable three to four fingers below the costal margin, but this was not subsequently confirmed. Heart and lung findings were negative. There were no neurological abnormalities except for disorientation and stupor. The R.B.C. was 4.1 million. The W.B.C. was 19,000. Differential smear showed Stabs 14 per cent, segmented neutrophiles 79 per cent, and lymphocytes 7 per cent. The hemoglobin was 12 grams per 100 c.c. The blood smear failed to show malaria organisms.

Although a clinical diagnosis of malaria could not be confirmed, the patient was treated with chloroquin diphosphate. On March 14 his temperature dropped to 100° and subsequently became normal. At this time he complained of aching in his back and large joints. The neurological examination was still negative and both the Kernig and Brudzinski signs were absent. He still appeared stuporous and confused.

The "therapeutic test" for malaria was interpreted as positive on March 15. The patient was afebrile. His continuing abnormal mental state, nevertheless, caused concern. On March 16 there was evidence of polyarthritis involving the wrists and ankles. The temperature rose to 100°. There were still no localizing neurological signs. He was receiving chloroquin 250 mgm. twice daily, and primaquin 15 mgm. daily was started. Another malaria smear was negative. On March 17 the temperature rose to 102°. The patient was semicomatose and difficult to arouse. Reexamination failed to reveal a Kernig's or Brudzinski's sign, and there was no nuchal rigidity. Because of the patient's mental state a lumbar puncture was performed. Cloudy fluid under pressure of 470 mm. of water presented. A smear revealed gram negative intracellular and extracellular diplococci. The fluid contained 6,600 W.B.C. per cubic millimeter. Differential smear showed these to be 95 per cent polymorphonuclear cells and 5 per cent lymphocytes. Cerebrospinal fluid glucose was 39 mgm. per cent. The chlorides were 96 meq. per liter. Culture was later found to be positive for meningococcus. Five grams of sulfadiazine intravenously was given followed by 2.5 grams of sulfadiazine every eight hours. 500,000 units of crystalline penicillin was given intramuscularly every three hours. There was a slight drop in rectal temperature from 104° to 102.4° on March 18, but following this the temperature rose to 106.4°. He expired on March 20, 1959. Necropsy was not performed.

Comment

The lack of localizing meningeal signs in this patient is striking, and unquestionably contributed to his death. The mortality rate in bacterial meningitis correlates with delay in treatment. This patient had no physical signs suggesting meningitis four days following his hospitalization. At this time a lumbar puncture was performed because of his abnormal mental state. He failed to develop nuchal rigidity even unto extremis.

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Case II: 62-2820

A 73 year old white female was admitted to the hospital on March 27, 1962. She had been found in a stuporous condition by her daughter. The patient was unable to communicate. Her daughter stated that the patient had been well except for a recent cold. On the day prior to admission she had complained of pain in the right ear accompanied by a rumbling sound. She had felt a "pop" in the ear and some blood had presented at the canal. She had also complained of pain on the right side of her neck below the ear.

Physical examination revealed a hyper-kinetic; almost maniacal female who was continuously thrashing about. Rectal temperature was 103°. There were no localizing neurological signs. Kernig's and Brudzinski's signs were not elicited. There was no nuchal rigidity. Later the same day the patient spontaneously became more relaxed. A careful neurological examination was repeated. Again, no nuchal rigidity, Kernig's or Brudzinski's were elicited. The right ear drum appeared hyperemic, and a small amount of mucopurulent exudate was noted in the right external auditory canal. The blood pressure was 190/80. The heart appeared slightly enlarged to the left. The cardiac rate was 100 per minute, and there was an irregularity of the rhythm. There were no murmurs and the rest of the physical examination was essentially negative. An electrocardiogram showed a sinus tachycardia and non-specific T wave lowerings in V4. Brain abscess secondary to right otitis media was the initial impression.

Because of the patient's thrashing about, it was decided to postpone lumbar puncture a few hours until she became more docile. She was treated supportively with fluids and given sedation. Procaine penicillin, 600,000 units every 12 hours was given for the otitis media. Early the next morning (March 28) the patient was still hyperkinetic and unresponsive. Re-examination at this time revealed questionable nuchal rigidity. In spite of the patient's mental state a lumbar puncture (which was traumatic) was performed. The fluid obtained was cloudy and under increased pressure. Manometric reading was not obtained due to the extreme haste necessary to avoid having the spinal needle snapped because of the patient's movements. Examination of the fluid revealed the total protein to be 75 mgm. per 100 cc. 70 red blood cells, 120 lymphocytes, and 60 polymorphonuclear leukocytes per cubic millimeter were reported. A Gram stain failed to show bacteria.

Five grams of sulfadiazine were administered, followed by 2.5 grams every eight hours. 500,000 units of crystalline penicillin every three hours was administered. On March 29 when culture revealed the offending organism to be pneumococcus, therapy was changed to two million units of penicillin intravenously every two hours.

On March 30, 1962 the temperature dropped to 102° and later to 99.4°. The rectal temperature remained between 98.6° and 100° thereafter. Later that day she responded verbally and began taking oral nourishment. On April 1, 1962 she was mentally alert, ate well, and appeared to be recovering. On April 2, 1962 she suddenly became dyspneic and coughed up large amounts of white mucoid material. She stated that she did not feel well. A house physician was summoned. When the nurse returned with the physician they found the patient dead. Autopsy was refused by the relatives.

Summary

The absence of localizing meningeal signs in this case did not result in any great delay in diagnosis because of the otitis media apparent on initial examination. Meningeal signs appeared on the second day of hospitalization making this case less striking than the first described. Apparently her infection was responding to therapy when she suddenly died of a cardiovascular or pulmonary catastrophe.

Hyland[5] has stressed that physicians should always be alert to the possibility of septic meningitis whenever headache and unexplained fever are encountered. This is especially true in the elderly even in the absence of signs which are usually found with meningeal irritation. It has been stated[6] that the presence of an underlying disease or injury such as brain tumor, congenital defect, head injury, leukemia and carcinomatosis may mask a meningeal infection by obscuring the usual clinical findings. To these states should be added that of old age.

Two cases of bacterial meningitis in elderly subjects did not initially have the characteristic signs of meningeal irritation. Both patients were irrational at the time of admission to the hospital. The first case, that of a meningococcal meningitis, never developed signs. In the second case, that of a pneumococcal meningitis, a complicating otitis media developed physical findings suggesting meningitis on the second day of hospitalization. It is recommended that all elderly subjects with fever of obscure origin and whose sensorium is distorted be subjected to diagnostic lumbar puncture regardless of physical findings.

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Uteroplacental Apoplexy: A Case Report

Charles E. F. Ahlm, M.D. and John B. Moore, M.D.

The complete separation of a normally situated placenta prior to delivery is unusual, occurring approximately once in five hundred gestations. The unusual pathology which may follow, profuse intrauterine hemorrhage from placental separation, was well described by A. Couvelaire in 1912 in his classic paper, "Deux Nouvelles Observations D'Apoplexie Utero-Placentaire."[1]

Since hemorrhage is the foremost cause of maternal mortality, it is our purpose in this case report to stress the clinical findings of antenatal placental separation, and to emphasize the dangers of the severe complications which may occur secondary to this condition.

Case History

A seventeen year old primigravida was first seen in her twenty-fourth week of gestation. Her past history was negative except for the usual childhood diseases. The prenatal care in this patient consisted of one office visit on December 12, 1962 when examination revealed a normal pregnancy of approximately five months duration. The patient's last menstrual period began on July 15, 1962. Her blood pressure was 120/80. The uterus was approximately at the level of the umbilicus. A slight trace of generalized edema was noted, but there were no other abnormal physical findings. The fetal heart tones were audible and of good quality. Her urine was negative for sugar and albumin; the RBC was 3,3100,000, with a hemoglobin of 11.75 grams. The VDRL was negative. Her blood type was O positive. The patient was placed on a low salt diet and given a prescription for supplemental vitamins and calcium. She was instructed to return in three weeks for her next prenatal visit.

The patient was next seen on the day of admission to The Franklin Hospital on January 3, 1963. The chief complaints on entry were nausea, vomiting, weakness, and infra-umbilical abdominal cramps. These symptoms began approximately four hours prior to admission. The patient also stated that she had noticed a pink mucoid type of vaginal discharge.

On her arrival at the hospital, the patient appeared pale and apprehensive. Her oral temperature was 97.8 degrees, pulse 116/minute, respiration 28/minute, and her blood pressure was 102/58 mm hg. The skin was slightly moist and cool. Examination of the abdomen revealed the fundus of the uterus to be approximately three inches above the umbilicus, and was firm and quite tender. The bowel sounds were present but hypoactive. No fetal heart tones were present. Pelvic examination revealed no evidence of external bleeding. The cervix was undilated and no effacement was present. The head could be palpated over the inlet and was unengaged.

The laboratory findings were as follows: Hemoglobin 7 grams with a hematocrit of 22 per cent; WBC 8,850 with a slight shift to the left. Catheterized urine revealed a three plus albumin, no sugar, several WBC's per h.p.f. The serum fibrinogen was 40 milligrams.

The patient rapidly became more restless and apprehensive. The blood pressure remained stable, but her pulse rate rose to 124 per minute, and the symptoms of shock became more evident. A diagnosis of abruptio-placenta was made and a surgical consultation was obtained.

Surgery

Approximately four hours following her admission, the patient was taken to the operating room. A Cesarean Section was performed under general anesthesia. A midline suprapubic incision was made. Upon opening the peritoneal cavity, the intra-abdominal organs appeared negative with the exception of the uterus and broad ligaments. The uterus appeared tense and distended, and had a purplish gray color. There was an extravasation of blood into the broad ligaments. The uterine veins were filled with clots.

The uterus was opened through a classical midline incision. Upon opening the uterus, it was found to contain approximately 1500 cc of liquid and clotted blood. The placenta was floating free in the uterine cavity, and there was a stillborn fetus of approximately five months gestation. The blood, fetus and placental tissues were quickly removed and the uterus was then massaged.

In spite of uterine massage, and the use of ergotrate and pitocin given intravenously, the

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uterus remained atonic and gray in color. One ampule of pitocin given directly into the uterine musculature failed to elicit a contraction. After observation of the uterus for approximately fifteen minutes, it was decided that the uterus would not regain its contractility because of the uteroplacental apoplexy. Confronted with this situation, it was reluctantly decided to carry out a supracervical hysterectomy.

This was performed without difficulty except for moderate generalized oozing, apparently due to hypofibrinogenemia. During the procedure, a total of four units of whole blood and three grams of fibrinogen were administered.

Post operatively the patient did well and was discharged on the sixth post operative day. The pathological examination report was as follows:

> "Grossly the uterus measured 11.5 x 8 x 8 cm. There is extensive hemorrhage into the edematous uterine wall. Microscopically there is edema and hemorrhagic extravasation extending into the uterine musculature while there is a moderate infiltrate of polymorphonuclear leucocytes into the area."

Results

This case classically illustrates the cardinal symptoms and signs of complete premature detachment of the normally implanted placenta and uteroplacental apoplexy. The sudden onset of cramp like abdominal pain, nausea, vomiting, the symptoms of acute anemia, and impending shock, with a tense overdistended uterus and accompanying hypofibrinogenemia confirm the suspicion of uteroplacental apoplexy.

The diagnosis at surgery is, of course, obvious from the color and appearance of the uterus with infiltration and extravasation of blood into the broad ligaments. In severe cases the uterus cannot be made to contract and, therefore, treatment by prompt supracervical hysterectomy is indicated.

Had this patient sought prenatal care earlier in her pregnancy, we may have been able to avoid the accompanying toxemia which certainly predisposed to this grave complication of pregnancy. That this is not purely a supposition has been postulated by Falls and others. While uncommon, profuse intrauterine hemorrhage can occur with complete placenta separation and uteroplacental apoplexy, without evidence of external bleeding, and procrastination might certainly prove disastrous.

Summary

Premature detachment of the placenta is unpredictable. It is more common in patients showing some degree of eclamptogenic toxemia which is rarely seen in a pregnancy as early as this case. The diagnosis is readily made in most cases from the sudden onset of abdominal pain and signs of shock. Failure to elicit evidence of fetal heart beat and fetal movement, nausea, vomiting, lower abdominal pain, bloody discharge, pallor, rapid pulse and low blood pressure makes the diagnosis almost infallible.

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Comparative Results of Smallpox Revaccination Using Regular and Dry Smallpox Vaccine (Dryvax)

Frederick Plotke, M.D., M.P.H.* and Eugene S. Lazowski, M.D.**

This study was performed for the purpose of comparing the results of vaccination with the regular smallpox vaccine and the new dry vaccine, "Dryvax." "Dryvax," prepared from calf lymph, is purified anl dried by lyophilization.

Since the regular vaccine is a living vaccine, it must be kept frozen until ready for use. This has been very inconvenient. A new freeze-dry smallpox vaccine has been developed and is now available under the name "Dryvax." It is a dry powder which can be kept at room temperature for six months or a year before being reconstituted as a fluid vaccine. A vial of phenolized glycerine is supplied for reconstituting the vaccine. After reconstitution it must be handled as the regular vaccine—kept in the freezing compartment of a refrigerator.

Only one lot was represented in the regular vaccine. Only one lot of "Dryvax" was used. Each "Dryvax" vial contained 100 doses and the expiration date was a year later. The reconstituted vaccine was used over a period of two or three days.

The 600 patients were divided into three groups. The first group was vaccinated only with the regular and the dry smallpox vaccine. The second group received typhoid vaccine simultaneously with the smallpox vaccine. The third group was given diphtheria-tetanus toxoid simultaneously with the smallpox vaccine. Since all of the patients had been vaccinated previously, the procedure amounted to revaccination.

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The multiple pressure method was used and the reactions were read by a single operator. Simultaneous inoculations were injected in the opposite arm. Local and systemic reactions were observed.[1,5] Special attention was paid to the ease of administration for both types of vaccine.

Group 1

A group of 100 patients was vaccinated with regular smallpox vaccine, while another group of 100 was vaccinated with the new dry smallpox vaccine, "Dryvax." Reactions were read on the third and the eighth days.

Results with Group 1

It was possible to evaluate 99 of the 100 patients who had received the regular smallpox vaccine.

Table 1

Types of Local Reactions	Number of Cases	Percentage
Immune reaction	3	3%
Accelerated take	92	92%
Primary take	4	4%
No take	0	0

Systemic reactions among patients revaccinated with regular smallpox vaccine were as follows:

1. Malaise with temperature (over 100° F.) was found in 2 cases (2%).
2. Malaise without temperature was found in 3 cases (2%).
3. Enlargement of the axillary lymph nodes was found in 2 cases (2%).

Results were obtained on all of the 100 patients vaccinated with "Dryvax."

Table 2

Types of Local Reactions	Number of Cases	Percentage
Immune reaction	3	3%
Accelerated take	89	89%
Primary take	7	7%
No take	1	1%

Systemic reaetions oecurred among patients vaccinated with "Dryvax" as follows:

1. Malaise and elevation of temperature (over 100° F.) were found in 4 cases (4%).
2. Malaise without temperature was found in 1 case (1.1%).
3. Enlargement of the axillary lymph nodes was not found.

Group 2

The purpose of the second part of this study was to determine if any difference occurred in the local reactions when the patient was vaccinated simultaneously with typhoid vaccine.[3,4] Regular smallpox vaccine was administered in the right arm to 175 patients. "Dryvax" was administered to 135 patients in the same way.

Results with Group 2

Among the 175 patients who received vaccination using regular smallpox vaccine, 172 were available for evaluation.

Table 3

Types of Local Reactions	Number of Cases	Percentage
Immune reaction	8	4.6%
Accelerated take	146	84.9%
Primary take	9	5.2%
No take	9	5.2%

Among the 135 patients vaccinated with "Dryvax" simultaneously with typhoid immunizations, 130 patients could be evaluated.

Table 4

Types of Local Reactions	Number of Cases	Percentage
Immune reaction	3	2.3%
Accelerated take	111	85.4%
Primary take	16	12.3%
No take	0	0

Group 3

The 100 patients in the third group were vaccinated with regular smallpox vaccine or "Dryvax" simultaneously with diphtheria-tetanus immunization.

Results with Group 3

The following results were obtained for the 49 patients vaccinated with regular smallpox vaccine.

Table 5

Types of Local Reactions	Number of Cases	Percentage
Immune reaction	0	0
Accelerated take	41	85.7%
Primary take	10	20.4%
No take	0	0

Evaluations of the 50 patients vaccinated with "Dryvax" are given below:

Table 6

Types of Local Reactions	Number of Cases	Percentage
Immune reaction	0	0
Accelerated take	40	80.0%
Primary take	10	20.6%
No take	0	0

Conclusion

For comparing the results when either regular or dry smallpox vaccine was used on 600 patients, the following findings were obtained:

1. More primary takes were recorded when "Dryvax" was used. (Dryvax: 11.7%, regular vaccine: 7.2%).
2. The difference with regard to immune and accelerated takes was not significant.
3. Local and systemic reactions did not show any essential differences.
4. No differenee in the type of reaction was observed when both regular or dry smallpox vaccine were administered simultaneously with typhoid vaecine or diphtheria-tetanus toxoid.

Acknowledgement

The dry smallpox vaceine, "Dryvax," used in this study was generously supplied by the Wyeth Laboratories.

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The History of Neurology in Chicago

Roland P. Mackay, M.D., *Chicago*

Henry Munson Lyman was another of the most scholarly members of the medical profession. Born in the Kingdom of Hawaii November 26, 1835, he received the B.A. degree from Williams College in 1858, the M.A. in 1876. After spending his first year of medical schooling at Harvard, he graduated in medicine from the College of Physicians and Surgeons in New York in 1861. After serving as house surgeon at Bellevue 1861-2, he entered the medical service of the United States Army and was sent to Nashville. In 1863 he resigned his military post because of poor health and came to Chicago to set up his private practice in neuropsychiatry. Dr. Lyman described his arrival in Chicago in October 1863 in a memorable and vivid passage.[13] On his arrival he sought out Dr. N. S. Davis, the autocrat of the medical scene in Chicago, in order to ask his advice on how best to introduce himself to the medical profession, preparatory to setting up his practice. Dr. Davis invited him to join the Chicago Medical Society, and offered to propose his name for membership. A few evenings later Lyman attended when the society met in a doctor's office on the second floor of a building on Clark Street near Monroe. (There were no doctors' offices above the second floor, since, without elevators, more than one flight of stairs would have been too much for many patients to ascend.) That night, Lyman continues, "something had happened to the gas, or there were no burners, and the room was lighted with candles stuck in beer bottles set around on the window sills and other available supports. I was a stranger to everyone till Dr. Davis, coming late, as always during his busy days, introduced me to the scanty contingent of members. There was Dr. G. C. Paoli, (now) lately deceased; Dr. Smith, a venerable Vermonter of the ancient type, who did not believe in the. . . . aid of the stethoscope; Dr. Grosbeck, a gentleman in every sense of the word, who could hardly be persuaded that the vaginal speculum was not an indecent instrument; Dr. E. L. Holmes, an apostle of light for the eye, recently from Vienna and the founder of a little struggling eye infirmary now the successful Illinois State Hospital for Diseases of the Eye and Ear. Several other lesser lights were endeavoring to shine in the darkness, but an early adjournment was deemed advisable, and I went home rather disappointed."

This is the second installment of an informative history of neurology not only in Chicago as the title would indicate but throughout the state and the nation. In a delightful and interesting style, Dr. Mackay paints a picture of the growth of neurology as seen against the times in which it was practiced—a story of a city and specialty growing together.

Dr. Lyman proceeds further in his account to describe a scene at the almshouse at Dunning, the lineal ancestor of today's Chicago State Hospital. Upon his arrival he sought out the keeper whom he pictured as "a jovial old farmer (who) resided in a wooden house with a few retired gentlemen and ladies for whom he provided board and lodging at the expense of the county. In another wooden building were some beds where were laid several sick people for whom medicines were doled out two or three times a week by a venerable physician who drove from the city for that purpose. In an adjoining wing were half a dozen cells for the reception of violently insane patients. At the time of my visit there was but

Read before the International College of Surgeons, Chicago, Illinois, March 19, 1963. Excerpts of this article appeared in the Journal of the International College of Surgeons, August, 1963 under the same title.

Professor of Neurology, Northwestern University Medical School, and Senior Attending Neurologist, Chicago Wesley Memorial Hospital.

*For much of the material here presented on the general history of Chicago, I am deeply indebted to Emmett Dedmon's *Fabulous Chicago*.[1]

one inmate in this department of the institution. We could see him through a little open window in the solid door of the cell—a stalwart fellow, standing stark naked on the straw on the floor quietly plastering himself all over with his own excrement. As we stood outside conversing together, the keeper inadvertently placed his hand on the edge of the opening of the door, all the while looking towards the doctor with whom he was conversing. The maniac saw his chance, and, before I could utter a word of warning . . . delivered with his fist a tremendously painful blow upon the back of the keeper's hand—then resumed his original occupation of salving himself with ordure."

On December 30, 1865, Lyman was made "Curator of the Dead House" of the Cook County Hospital, but had only a knife, saw, chisel and mallet—no microscope, no alcohol and no jars for specimens. He remained in this office until 1870. As a further evidence of his versatility we note that he was quiz master at Rush in the winter of 1865-6 and lecturere on physiology in that medical school from 1866-9. He was Professor of Chemistry and Pharmacology from 1871-7, when he became Professor of Physiology and Diseases of the Nervous System, a post which he held until 1890. In 1875 he was, with Walter Hay and James S. Jewell, a Founding Father of the American Neurological Association. In 1877 he was the first to begin clinical (as opposed to didactic) instruction in neurology at Rush, where the only preceding clinical instruction was at the surgical clinic of Marcus Gunn. In 1890 he became Professor of the Principles and Practice of Medicine and continued in that office for 10 years, till 1900. He held the same post at the Woman's Medical College from 1880-8, was Attending Physician at the Cook County Hospital from 1867-76 and was a member of the staff of the Presbyterian Hospital from 1884 until retirement. He was President of the Association of American Physicians in 1891 and of the American Neurological Association in 1893. He was a charter member of the Chicago Neurological Society, in 1898.

Dr. Lyman's contributions to the neurological and general medical literature were considerable, including a chapter on the disorders of sleep in Pepper's System, a textbook of medicine, a monograph on anesthesia and sundry articles on neurologic topics. Moyer says of him that he was an omniverous reader, and that, for him, to read was to remember. He read French, German and Italian with ease and accuracy, and wrote "Addisonian English." His was a scholarly, classical mind, but he was not a conspicuous clinician or research scientist. He retired in 1900 and died 4 years later at 69, a man who left his mark on neurology in Chicago and in the nation.



Henry Munson Lyman
(1835-1904)

Henry Martyn Bannister began his practice of neurology and psychiatry in Chicago in 1874, having already had one career as a geologist. Born the son of a clergman at Cazenovia, New York on July 25, 1844, he received the Ph.B. degree from Northwestern University in 1863 and in 1867-8 took part in the geological survey of Illinois. In 1869 he was awarded the A.M. degree by Northwestern, and graduated in medicine in 1871 at the National Medical College, Washington, D.C. In 1872 he was a member of a party which made a United States Geological Survey of the western territories, including Alaska, just 5 years after the purchase of "Seward's folly." After setting up his office in Chicago in 1874, he at once joined Jewell as co-editor of the new Chicago Journal of Nervous and Mental Diseases. He held this editorial position until 1880 when he moved to Kankakee to become assist-



Henry Martyn Bannister
(1833-1920)

ant superintendent of the State Hospital there. He was also one of the original members of the American Neurologieal Association, before whieh he presented many papers. Some of his artieles were entitled, (1) "Moral Insanity" (1877); (2) "Gunshot Wound of the Neck—Paralysis of the Cervical Sympathetie, Followed by Insanity" (1879); (3) "Perieneephalitis and Meningitis" (1880);; (4) "Color Blindness" (1881); (5) "Bromide Mania and the Supposed Compensatory Aetion of Epileptie Attacks" (1882); (6) "Raee and Insanity" (1888, with Hektoen); (7) "General Paresis" (1888); (8) "Foeal Hemorrhagie Lesion of the Anterior Cerebellar Crus" (1890); and (9) "The Home Treatment of Insanity" (1895). He was also eo-author with Dr. Daniel R. Brower of a textbook of insanity.[14] He was a eharter member of the Chieago Neurological Soeiety and for years was a member of the editorial staff of the Journal of the Ameriean Medical Association.

Bannister suffered severely from arthritis deformans, and was an invalid, restricted to his home in Evanston for 14 ycars prior to his death in 1920. This chronie affliction no doubt explains why his neurologie labors appear from the available records to have been more editorial and literary than investigative and edueational. It has been said of him that "he was a man wonderfully well read in medical seienee, and was learned, not only in his own speeialty, but in the broad fields of literature and scienee."

The Chicago Setting, 1875-1900

In the next quarter-eentury, 1875-1900, eame a time when this Chicago, gargantuan and predatory village, first sensed its need for something more real than gaudy ostentation. In the midst of wealth and poverty, bitter strife and endless turmoil, there were subtle stirrings of adoleseent urbanity and a young vision of righteousness and eulture and the arts. It was a time of unbridled eommereial exploitation, of "robber barons" and the seething poor, but also of the still, small voiee of soeial justiee. It remained the age of shameless viee but became the age of militant virtue. It was the period of the infamous politieal boss and gambler, Mike McDonald, a hireling mayor, brawling bulletary in the streets, and the gospel by Dwight L. Moody. The tide of immigration was at its flood, hordes of Europe's poor brought a polyglot of native languages and the revolutionary ideology of the dispossessed. Surplus labor drove wages down, the unemployed slept on rags in the City Hall, mobs prowled the pavements and the Marseillaise was sung in Monroe and Haymarket Streets. Brieks and stones were met by poliee gunfire and blood triekled into the gutters. A United States Cavalry troop escorted meat trains from the stoek yards and Cleveland's soldiers broke the Pullman strike, while Governor Altgeld's toleranee and humanity were gentle harbingers of a better future.

In the meantime, Theordore Thomas skillfully wooed the eity from popular to elassieal musie and the World's Columbian Exposition dramatizcd the dawning age of teehnology. The somewhat eallow esthetes of the eity were bedazzled by the talents of the divine Sarah Bernhardt, the wit and exotic airs of Osear Wilde, the arts of Madame Helena Modjeska, and the sublime voiee of Adelina Patti, while the great era of Chieago arehiteeture was introdueed by Dankmar Adler and Louis Sullivan who ereetcd the greal Auditorium as a monument to sophistieation and the future. William Rainey Harper from Yale made friends with John D. Roekefeller and inveigled from him a eontinuing largess for a new University of

Chicago which was opened on October 1, 1892, stocked with a brilliant faculty of 120 and a student body of 600. Martin A. Ryerson, with Chicago "hustle," beat European buyers to the draw and spent fabulous sums for art treasures by Hals, Hobbema, Rembrandt and El Greco for the new Art Institute, already graced with the rich collection from the Palmer mansion. Thus to the raw frontier community came the first graceful messengers of learning and the gentle arts.

In matters of medical education, these last 25 years of the century were fruitful for Chicago. Rush Medical College, the oldest in the state, occupied in 1876 new, large quarters at the northeast corner of Wood and Harrison Streets, and in 1884 the Presbyterian Hospital opened, to increase its teaching facilities by 80 beds. In 1880 Rush affiliated with the new University of Chicago, a union destined to bring about its death in 1943, the one hundredth year of its existence. Northwestern University Medical School, which had been the medical department of Lind University from 1859 to 1861, and then the independent Chicago Medical College until absorbed into Northwestern in 1869, was thriving at a location next to Mercy Hospital and using also the facilities of St. Luke's and Wesley Hospitals. In 1891 Northwestern also absorbed the Woman's Medical College. Finally, the College of Physicians and Surgeons of Chicago, founded in 1881 through the energetic efforts of Charles W. Earle and four associates, opened in 1882 with 100 students and was leased to the University of Illinois in 1887, eventually to become, in 1913, the College of Medicine of that university. Yet to come after the turn of the century was Loyola University and its medical school, but the awakening city was already well equipped for the training of its physicians.

The Neurologic Scene, 1875-1900

In this florid quarter-century of tumult and growth, Chicago's neurology, too, came of age. Edward Mead had died in 1873 and John Evans was reshaping the face of Colorado, but Hay, Jewell and Lyman were still busy at both neurology and psychiatry, while the ailing Bannister was writing and pursuing his editorial work. But newcomers arrived, some from a distance, but others home-grown, in numbers sufficient to fill up and enlarge the ranks of neurologists. Like their predecessors, most of them also embraced psychiatry, but for the first time, toward the end of the century, unadulterated neurologists appeared on the scene. These new men were still clinically oriented. Only in the twentieth century would Chicago begin to see the comparative neuroanatomist, the neuropathologist, and that truly modern species, the neurophysiologist.

For Chicago neurology, the greatest event in the final quarter of the nineteenth century was the founding of the Chicago Neurological Society, on January 5, 1898. This act of organization transformed the city's individual neuropsychiatrists into a cohesive and continuing group which has to this day provided for their personal and scientific communion.

Let us look, then, in some detail at the men, 13 in number, who entered the Chicago neurologic arena in the final 25 years of the nineteenth century.

Daniel Roberts Brower was born near Philadelphia on October 13, 1839, graduated from Polytechnic College of Philadelphia in 1860, with the degree of M.S. and from the medical department of Georgetown University, Washington, D.C. in 1864, with the degree of M.D. He was thereupon commissioned Assistant Surgeon and assigned to the United States General Hospital at Portsmouth, Virginia and later at Fortress Monroe. After the Civil War he was Surgeon in Charge of Howard's Grove Hospital and of the Freedman's Bureau until 1868. He then became Superintendent of the Eastern Lunatic Asylum of Virginia at Williamsburg, and served as such until 1875 when he resigned to come to Chicago, to practice in nervous and mental diseases.

In 1877, Brower was made Professor of Nervous Diseases at the Woman's Medical College, where he built up "an excellent clinic" and once a year held a clinic for the Woman's senior class at the Cook County Insane Asylum at Dunning. At Rush Medical College he was lecturer on the theory and practice of medicine from 1883-9, when he became lecturer on mental diseases, materia medica and therapeutics. In 1891 he became Professor of Mental Dis-

eases, Materia Medica and Therapeutics, a position he held until 1899. He was also Professor of Nervous and Mental Diseases in the Postgraduate Medical School and neurologist at St. Joseph's and Cook County Hospitals as well as consulting physician to Woman's and Presbyterian Hospitals.

In 1893 he was elected to membership in the American Neurological Association, and in 1898 he read a paper before that association on "Some Observations on the Diagnosis and Treatment of Acute Meningitis." In 1894, as President Elect of the Illinois State Medical Society, he noted and deplored that while there were 6,000 doctors in the state, there were only 600 members of the state society. In 1895 Brower gave as his Presidential Address to the state society an illustrated lecture on "Some Abnormalities of Physical Conformation Observed in Criminals, with Causative and Corrective Considerations." With Bannister, he wrote a textbook on insanity.[14]

Dr. Brower was one of the original members of the Chicago Neurological Society, founded in 1898. He was president of the Chicago Medical Society in 1891, wrote voluminously on neurologic topics, and received the Doctor of Laws degree from Wabash College, St. Ignatius College and Georgetown University. He died March 1, 1909.

Richard Smith Dewey, born in Forestville, New York in 1845, graduated in medicine at the University of Michigan in 1869, studied in Germany under Virchow and, turning to Illinois, became in 1879 the first superintendent of the new Eastern Illinois State Hospital for the Insane at Kankakee. There he introduced many improvements, including the practice of non-restraint and the "cottage system" of organization. When Altgeld became Governor of Illinois in 1893, Dewey resigned his superintendency at Kankakee to make way for Clevenger. In 1894 he assumed the professorship of nervous and mental diseases at the Chicago Postgraduate Medical School and became lecturer on psychiatry at the "Chicago Detention Hospital," the ancestor of the Cook County Psychopathic Hospital. His teaching was thus all at the postgraduate level. In Milwaukee he established and directed for 25 years a private sanitarium for nervous patients which influenced institutional psychiatry throughout the middle west, while his learning and integrity earned respect for him as a medico-legal expert. He was elected to the American Neurological Association in 1891 and read a paper entitled "Clinical Study of a Case of Dreamy Mental State" before that group in 1896. He was a charter member of the Chicago Neurological Society. His writings were all psychiatric, and revealed his wide interest in scientific, legal, social and administrative aspects of that specialty. In 1900 he retired to California where he died in 1933.

(To be Continued)

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Gout in Women

E. F. Traut, M.D., Frank Kostal, M.D.,
F. Volini, M.D., Oak Park, Illinois

Primary gout may be defined as an inherited metabolic trait manifested by abnormal metabolism of urate. One characteristic of primary uncomplicated gout is hyperuricemia, which is selective in the sense that other nitrogenous partition products are not affected. Clinical proof of gout is demonstrated by aggregates of urate crystals; tophi, usually in joints, other cartilaginous structures in the urinary tract; and calculi.

Practically speaking, clinical gout, gouty arthritis, is a disease of males. Estimates of gouty arthritis in females vary from 3 to 15 per cent.[1,2] Four hundred women were reported to have died of gout in Great Britain in the decade ending in 1942.[3]

Most diagnoses of gouty arthritis in females are based on the detection of hyperuricemia and arthropathy, often supported by roentgenologically demonstrable punched-out areas. Hyperuricemia, episodic arthritis characteristically distributed (podagra), and roentgenologically demonstrable punch-out lesions are all marks of gouty arthritis in the male. These criteria, which are acceptable in establishing a diagnosis of clinical gout or gouty arthritis in a male, are not "indubitable" in substantiating a diagnosis of primary gout in a female patient.

We have repeatedly corrected clinical impressions based on the above findings by recovering cholesterol crystals or detritus (resulting from degenerative processes) from bursae, joints or presumed tophi. In the experience of the senior author gouty arthritis in a female patient is so unusual as to require only pathognomonic criterion, the demonstration of urate crystals from a joint or tophus.[4]

From the West Suburban Hospital Oak Park, Illinois and The Cook County Hospital Arthritis Clinic Chicago, Illinois

Report of a Case

Mrs. E. F., a 73 year old white widow, first consulted Dr. Kostal on March 17, 1959. She had had pain, swelling and tenderness in the terminal joint of the third digit in her right hand for one year. The finger joint had gradually become red, swollen and painful enough to prevent sleep for two weeks after she had struck the finger against the edge of a window. She had not previously had to consult a physician about any joint inflammation, despite intermittent chronic pain in her feet for years. She had never had any acute manifestations. After enduring an inflammation in her right eye for 2 years the eye was enucleated in 1956. A varicose ulcer of the lower left leg had been excised in 1957 after draining for 10 years. The lens of the left eye had been removed because of cataract. She had never had any urinary difficulties.

She had a healthy adult son and daughter. The only disease recalled in her family history was an acute episode of "rheumatism suffered by her mother." This was a swelling of the hands which persisted for a number of weeks. There was no family history of kidney stones, other kidney disease, or high blood pressure.

According to the patient, her affected finger, the longest on her constantly used right hand, was "always in the way" and constantly striking things.

Physical Findings

The patient was a woman of average size. She weighed 121 lbs. Her height was 64 inches. Her color was good. She did not appear ill. Her blood pressure was 190/103. The left eye was aphakic; the right was supplanted by a prosthesis. The thoracic contents and abdomen gave normal findings. There were no tophi in the ears and no swollen bursae.

The affected joint was very swollen and red, resembling a very angry Heberden's node. The roentgenologist's report of this joint was "osteoarthritis with



FIGURE 1. X-ray of finger joint.



FIGURE 2. Photograph of toe.



FIGURE 3. X-ray of left great toe.

destruction of the intra-articular cartilages with osteophytosis, sclerosis and eburnation of the articular bone ends." The X-ray findings were compatible with Heberden's nodes and not suggestive of gout (Fig. 1).

The metatarsophalangeal joint of the great toe on the left foot was bonily enlarged (Fig. 2). Crepitus and tenderness were elicited. Roentgenologic study of both great toes showed a large tophus on the left, and punched-out areas in the right, great toe joints (Fig. 3).

Her serum uric acid was 6.7 mg. per 100 cc. She was given 1 gm. of probenecid daily.

At the next visit, Aug. 16, 1962, she and her children requested amputation of the very painful finger. The inflamed terminal joint had developed a sinus which was discharging a chalky material. This material contained typical long, needle-like urate crystals. The serum uric acid was 7.3 mg. per 100 cc. Urinalysis gave normal results. The finger was amputated at the metacarpophalangeal joint (Fig. 4).

Findings in Amputation Specimen

The amputation specimen of the right middle finger included the proximal, middle and distal phalanges. On the dorsal surface a small ulcer was noted in the skin one centimeter proximal to the cuticle. A whitish, chalky material present within this ulcer was continuous with a plaque-like deposit of similar material found in the subcutaneous tissue. When examined with polarized light, this material was found to consist of refractile needle-shaped crystals (Fig. 5). These produced a characteristic reddish-violet color when treated with nitric acid and ammonia (murexide reaction).

The subcutaneous urate deposit continued through the distal interphalangeal joint (Fig. 6), enlarging into a subcutaneous deposit on the flexor surface of the finger. On midline longitudinal section of the bone a similar whitish and chalky urate was seen within the medullary cavities of the distal and middle phalanges. The distal interphalangeal joint was obliterated by urate deposits. Its articular cartilage was not recognizable. The proximal interphalangeal joint appeared normal. Microscopically, trabeculae in the distal and middle phalanges were replaced by large urate deposits. Many of these were surrounded by foreign body giant cells (Fig. 7).

Fibrous tissue proliferation and collections of histocytes and lymphocytes were seen in some parts of the bone. Some intermedullary tophi were calcified. An acute inflammatory reaction had occurred in the area about the cutaneous ulcer. Sections of alcohol-fixed tissue, incubated in methenamine-silver[5] became intensely black at the sites of subcutaneous and intramedullary tophi. Portions of subcutaneous tophi were homogenized in the Waring Blender. Uric acid content of the homogenate was 550 mg. per 100 grams of wet tissue (method of Brown).[6] Subcutaneous tissue from non-tophaceous areas in the same specimen contained 15 mg. of uric acid per 100 grams of wet tissue.



FIGURE 4. Photograph of hand after amputation.

The tophus was also removed from the left great toe leaving a sinus to drain the urates.

Five days after these surgical procedures the patient's left knee became hot, swollen and very tender. This was taken to be an acute postoperative episode of gouty arthritis.

Discussion

This case was unusual because the patient had severe, chronic tophaceous gout which first manifested itself in a terminal interphalangeal joint with the clinical manifestations commonly seen in a Heberden's node.

A history of gout, said to be anticipated in the families of women with tophaceous gout, was lacking in our patient.

Women in gouty families are said not to develop hyperuricemia until after the menopause. "Gout" has been described in young women[2] who have a tendency toward acute episodes during menstruation.[7] Gout has been reported accompanying pregnancy.[8]

An abnormal androgen secreted by the adrenal cortex has been postulated as the determining factor in both male and female patients with gout.[7]



FIGURE 5. Urate crystals from ulcerated subcutaneous tophus, photographed with polarized light, x 430.



FIGURE 6. Longitudinal section of the surgical specimen showing subcutaneous tophi in continuity with intra-articular and intramedullary tophi.

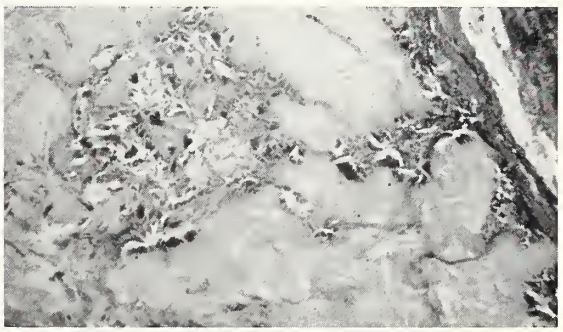


FIGURE 7. Intramedullary tophi surrounded by foreign body giant cells. H & E x 430.

In the patient described here, gouty arthritis appeared in the guise of an acutely inflamed Heberden's node. This is another possibly sex-linked arthropathy which appears characteristically in menopausal women. In the pathogenesis of gouty arthritis it is postulated that the acute clinical manifestations are due to the entrance of urate crystals into degenerated tissue such as cartilage damaged by trauma. In

our patient, the interphalangeal cartilages were degenerated by the development of Heberden's nodes.

According to the senior author, diagnoses of gouty arthritis in women are frequently erroneous. With gouty arthritis so very uncommon in the female sex, its diagnosis is hazardous unless it has been substantiated by the demonstration of urates in the joint tissues. Clinical diagnoses based on hyperuricemia, punched-out areas visualized roentgenologically, and relief by colchicine are likely to be in error.

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The Use of Codeine for the Relief of Pain in the Recovery Room

Max S. Sadove, M.D., Arthur T. Shima, M.D.,
Milton J. Schiffrin, Ph.D.

Like many others, we had accepted the conclusions of Wolff and Hardy[1] regarding the effectiveness of codeine for the relief of pain. One of the most widely accepted dictums was that a dose of 60 mg. Codeine produced as much analgesia as did larger doses. The standard texts in pharmacology support this view. They state that increasing the dosage over 60 mg. produces no further benefit to the patient. As a matter of fact, increased dosage causes reactions such as excitation. However, Houde[2] and his colleagues at the Sloan Kettering Institute reporting on their experience with doses of codeine far in excess of 60 mg, demonstrated that these larger doses could be used advantageously with benefit to the patient.

We have no reason to question the validity of the data representing these two different points of view. It is our belief that the differences in the conclusions are due to the fact that Wolff and Hardy used normal human volunteers and studied "experimental" pain induced by a radiant heat method. Houde and his co-workers, on the other hand, studied patients with clinical pain, and we confess our bias in favor of data derived from the clinic. Admitting this prejudice we still felt it necessary to study the use of codeine in order to see whether our results would favor the conclusions of Houde or those of Wolff and Hardy.

Procedures and Materials

As subjects for this study we employed patients in the recovery room who had such pain that it warranted the use of a narcotic. Records were kept of each patient's age, sex, time, and dose of all preoperative medications; the time interval between the administration of preoperative medications and the injection of the narcotic; the duration of surgery; and the time interval between the end of surgery and the start of the study. The only analgesic agent used in this study was *codeine phosphate*, 120 mg. This was given by intramuscular injection into the antero-lateral aspect of the thigh.

The following measurements were made prior to the injection of codeine, and also at 15, 30, and 60 minutes thereafter: pain, sedation, pulse rate, respiratory rate, respiratory minute volume, respiratory tidal volume, blood pressure, and untoward reactions.

The evaluation of pain and sedation was made by the observer, who graded the degree of pain or sedation on a scale of 1-9. In general, slight pain or sedation would be graded 1-3, moderate as 4-6, and severe as 7-9. We enlarged our usual scale (1-3) to this system of 1-9 in the hope that we might be able to refine our observations and pick up finer degrees of pain differentiation than were previously possible. RMVs were measured with the aid of a Wright Respirometer.

This study was carried out at two institutions, the Hines Veterans Administration Hospital and the West Suburban Hospital. Sixty patients were treated at Hines and 65 at the West Suburban Hospital.

Results

Because this study was carried out at two different institutions, an analysis was made of all pertinent factors to see if there were any significant differences between the two hospitals. The only such difference was that all of the patients at Hines were males, whereas only

From Departments of Anesthesiology, V.A. Hospital Hines, West Suburban Hospital, and University of Illinois Research and Education Hospital. Presented by A. T. Shima May 15, 1961, Section on Anesthesiology Ill. State Medical Society.

20 of the 65 at West Suburban were males. Ages of the patients ranged from 23-79 years. Average age of all patients was 50.3 years. Significant analgesic effect was produced by codeine in 92 of the 125 patients (73.6 per cent). This percentage of responses compares favorably with the common experience of about 80 per cent analgesic response to 10 mg. morphine sulfate.

Sixty-three of the 125 doses produced sedation. This was not just a mild sedative effect. The patients were, in fact, dozing or sleeping. It was our clinical impression that the sedative response was more frequent in elderly patients. This was borne out by analysis of the data. Forty-two of the patients were 60 years of age or more. Codeine produced sedation in 27 of these patients.

The overall incidence of sedation in the elderly group was 64 per cent, whereas sedation occurred in only 43 per cent of the other patients in the study. It was our impression that this sedative effect was highly desirable and advantageous to these elderly patients and helped to provide them with a smoother course in the recovery room.

Effects of Codeine on Respiratory Function

We were, of course, much interested in the effects of codeine on respiratory function. Although respiratory rates are not a good measure of respiratory function, records were kept for general information purposes.

In the entire group there were only 2 patients whose respiratory rate fell below 10/minute. In the first of these, the initial rate was 12. This rate fell to 6 just 30 minutes after injection of codeine. This patient was a 60-year old male who had a good analgetic response with considerable sedation. The patient's RMV at the start was 6 liters per minute and fell to 3.3 liters at 30 minutes and 9.8 liters at 60 minutes. The tidal volume never decreased below 550 ml. The pulse was regular and strong and the blood pressure remained stable. There were no clinical signs of cyanosis.

In the second patient, the respiratory rate decreased from 12 to 8 per minute. In this patient the minute volume never fell below 7 liters and the tidal volumes were more than adequate.

We have made an analysis of the RMV values since we wanted to compare these data with those obtained in our earlier studies.[3] It had been our experience that 25 mg. meperidine produced a decrease in the RMV to 73.4 per cent of control values. The use of 50 mg. of meperidine produced an even greater decrease in RMV. (62.5 per cent of the control average). The analysis of our data, using 120 mg. of codeine, indicated a decrease of RMV to 71 per cent. This result is in accord with older observations on codeine which indicate that the drug in the ordinary dosage usually produces less respiratory depression than is anticipated with the use of the other narcotics.

From a practical point of view, we consider it a clinical advantage to use a drug such as codeine which produces less respiratory depression than the common narcotics used for patients in the recovery room. These patients are emerging from a general anesthetic and the stress of surgical procedures. Their margin of reserve in many instances is less than normal. It makes good clinical sense to use an analgesic which has little depressant effect upon the respiratory system in these patients.

The data relative to pulse rate and blood pressure showed that these parameters were remarkably stable throughout this series. There was no incidence of bardycardia, tachycardia or significant change in blood pressure.

Less Than Five Per Cent Reactions

In view of all the cautions in the medical literature about the restlessness and excitement that are produced by large doses of codeine, we consider our experience relative to reactions to codeine to be significant. We never observed restlessness or exitation. The only reactions which we noted in these 125 patients were 4 individuals who experienced nausea and 2 who had both nausea and emesis. This reaction rate is a little less than 5 per cent.

In our previous studies with meperidine we found reactions such as these in 4 of 16 patients who received 25 mg. meperidine and in 7 of 16 who were given 50 mg. meperidine. However, we feel this data is not statistically significant because of the lack of controls and

types of surgery performed which is much more significant than the drugs administered. It appears that both as regards respiration and side reactions, 120 mg. of codine is to be preferred over either 25 or 50 mg. of meperidine in many instances, especially those with circulatory insufficiency.

Discussion

We believe that the data obtained in this study substantiate the earlier report by Houde and his colleagues regarding the usefulness of large doses of codeine for the relief of clinical pain. We have had verbal comments from some of our older colleagues that the intramuscular injection of codeine may produce pain and induration at the site of injection. These reactions were not observed in our study. We suggest that our colleagues in anesthesiology and surgery consider the use of codeine for the relief of postoperative pain because it is effective and safe.

Summary

1. A study has been made of the effects of 120 mg. of codeine given intramuscularly to 125 patients in the recovery room for the relief of pain.

2. Analgesia was produced in 73.6 per cent of the patients. Sedation was produced in about 50 per cent. Codeine in this dosage produced sedation in 64 per cent of the patients who were over 60 years of age.

3. Minimal respiratory depression was produced. The extent of this depression was less than that following 25 or 50 mg. meperidine. There were no adverse effects on the cardiovascular system.

4. The only untoward effects were nausea or emesis, which occurred in about 5 per cent of the patients. There was no evidence of restlessness or excitation.

5. These data support the findings by Houde and his colleagues, and we recommend the consideration of codeine for the relief of postoperative pain.

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Announcing *Preview of ISMS Convention Program*



Illinois Chapter, American College of Chest Physicians

DR. WILLEM J. KOLFF, Department of artificial Organs, Cleveland Clinic, Cleveland, Ohio, will speak on AN ARTIFICIAL HEART INSIDE THE CHEST.

Tuesday, May 19, 1964, at 6:00 P.M.

Sherman House, Chicago

The Value of Charting the Vital Signs in Premature and Newborn Infants:

A Method for Improving Communications Between Nurses and Physicians

Harvey Kravitz, M.D.*

Clement Smith[1] has appropriately referred to the first day of birth as "the valley of the shadow of birth." During this period the premature and the mature newborn infant must make a number of physiological adjustments if it is to continue its postnatal existence.

All infants are observed very closely during the first critical hours of extra-uterine life by nurses, internes, residents, and attending pediatricians. However, charting of the pulse rate and the respiratory rate are seldom routinely ordered by attending pediatricians.

One of the reasons frequently given for not charting the pulse and respiratory rates in newborn infants is that these rates are too irregular to be of any clinical value. This premise has been refuted by the investigations of Miller and his co-workers.[4] These studies have amply demonstrated that the vital signs do have a significant, proven clinical value.

It has also been assumed that nursing personnel assigned to nursery duty do not have sufficient time to count and chart the pulse and respiratory rates of newborn infants. Yet, hospital routine dictates that the vital signs must be periodically taken and recorded in cases of coronary disease, head injuries, in surgery, and in a multitude of other situations. It seems incongruous, therefore, to limit the obligatory charting of vital signs only to certain cases, while newborn infants—some of them critically ill—are excluded from this attention.

The blood pressure should also be recorded in certain cases.

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A Program For Charting Vital Signs

We have instituted a program of charting pulse and respiratory rates of premature and newborn infants in the nurseries of St. Francis Hospital. This system helps to improve communications between nurses and physician when serious abnormal signs develop in the newborn. Our program has the following objectives:

1. Closer observation of premature and mature newborn infants by the nurse and physician.

2. Closer cooperation and communication between the nurses in the nursery, the interns, resident, and attending pediatrician so that the attending man may be alerted to any serious abnormal signs that might arise as early as possible.

3. The charting of the vital signs is important in aseribing a clinical cause of death in infants who die suddenly. Too often there is no significant clinical information on the charts of premature and newborn infants. For this reason it is difficult to get an accurate diagnosis of the cause of death—even after autopsies have been performed.

4. The charting of the vital signs is important in ascertaining the value of new therapeutic agents.

5. The charting of the respiratory rate in the respiratory distress syndrome is especially important so that concentrations of oxygen can be better adjusted to the degree of hyperpnea and cyanosis of the patient.

Listed are some suggested regulations regarding charting of the vital signs and instruc-

tions pertaining to their communication between nurses, residents and attending physicians in the premature and mature nurseries:

1. The intern or resident on the nursery service shall record the heart rate and the respiratory rate of every premature and mature newborn as part of the infant's initial physical examination.

2. All premature newborn infants free of respiratory distress or cyanosis and who are otherwise normal, shall have the respiratory rate and the heart rate charted by the nurse every 3 hours for the first 24 hours. If the respiratory rate is between 35 and 60 respirations per minute, the charting of the respirations may be stopped. If the heart rate is between 100 and 180, the charting may be stopped.

3. All mature newborns free of respiratory distress, cyanosis and who otherwise are normal, shall have the respiratory rate and heart rate charted by the nurse on duty every 6 hours for the first 24 hours. If the respiratory rate is between 30 and 50 per minute, the counting may be discontinued by the nurse. If the heart rate is between 100 and 180, the counting may be stopped after 24 hours.

4. If a premature or a mature newborn has the following signs:

a. cyanosis
b. hyperventilation (respiratory rate over 80 per minute)
c. hypoventilation (respiratory rate below 30 per minute)
d. heart irregularities—
   1. bradycardia-heart rate below 90 per minute
   2. tachycardia-heart rate above 200 per minute
e. convulsions
f. fever
g. pallor
h. coma
i. shock
j. hemorrhage

the nurse will immediately notify the intern or resident on duty and the attending physician. The nurse will automatically start charting the respiratory rate and the heart rate every 1 hour. It is advisable that a written order be obtained from the intern or resident or attending physician.

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Profile of "Typical" Young Physician

A recent survey conducted by the Student American Medical Association, under a grant from Merek, Sharp & Dohme, Inc., provides this interesting profile of the "typical" young physician:

1. He chose medicine as a career because of the humanitarian aspects of the work.

2. He was influenced by others in making his choice—primarily his family, with other physicians, including his family doctor, a close second.

3. Few people have counseled him against a medical career.

4. It's a 50:50 chance he considered dropping medicine during pre-med training.

5. He believes the burden for recruiting new people to medicine rests primarily with the individual physician.

6. He feels that the major deterrents to the study of medicine are the time, effort and amount of study necessary, with financial burdens of secondary consideration.

7. He would encourage others to choose medicine as a career, and would make the same choice again himself.

The Doctors' Guide to Kerr-Mills: Aid to the Medically Indigent Aged, AMIA

Introduction

Aid to the Medically Indigent Aged (Kerr-Mills) was enacted by the Illinois Legislature in July 1961, and became effective the following month. Physicians supported its passage as a measure in warding off medical care financed by social security taxes for all over 65 regardless of need.

The purpose of the AMIA program is to furnish medical assistance to aged individuals who are not recipients of other categorical welfare programs and whose income and resources are insufficient to meet the cost of allowable medical services.

During the first two years of the program's operation, demands for service were less than originally anticipated by the Department of Public Aid.

As a result, provisions for eligibility were liberalized during the 1963 legislature, and subsequent administrative changes further liberalized the program in accordance with suggestions put forth by the Illinois State Medical Society and accepted by the Illinois Department of Public Aid.

The Kerr-Mills approach to financing medical care for the needy aged must be made to work as an effective tool in combating medical care financed through Social Security. To work successfully, physicians should endeavor to familiarize themselves with the general administrative policies; available services; general eligibility requirements; need for assistance based on income and resources; where applications may be made and details instructing the patient in the procedure to follow when making application for assistance.

This guide is intended to supply such information without being unduly burdensome. It is intended to provide a source for answers to questions frequently asked. It is not intended to replace the services of a social worker. Detailed information may be obtained from respective County Departments of Public Aid.

The Services listed below are designated "allowable medical services," set forth by the Department of Public Aid, with respect to the AMIA program.

Services Provided

The present program provides for:

A. In-hospital care in general hospitals (all counties), Includes essential diagnostic services when the required services must be done in the hospital.

B. Physicians' services during hospitalization (which *includes* post-operative care for 30 days in surgery cases) in downstate hospitals.

C. Post-hospitalization physicians' visits for 30 days after release from the hospital (all counties).

D. Cost of drugs dispensed or prescribed by the physician within the 30 day post-hospitalization period.

E. Post-hospitalization nursing home care up to 90 days from the date of hospital discharge, including physicians' services and drugs connected with such care; or up to 90 days rehabilitation nursing home care, provided the recipient can benefit from an intensive reha-

bilitation program, in a rehabilitation nursing home approved by the Department of Public Aid.

Nursing home care will be provided only when necessary and up to any time within 30 days after release from the hospital but only up to 90 days from the date of the applicant's discharge from the hospital. *Application will be accepted for hospital care only.*

General Eligibility Requirements

A. *Age.* The applicant must be 65 years of age or older.

B. *Residence.* The applicant must be a resident of Illinois and have established his permanant home here at the time of application, *but there is no durational residence requirement.* Temporary absence from the state does not affect his residence status if he applies for care while in a hospital or institution when in another state.

Need for Assistance: Income and Resources

A. *Income:* Income means all earnings, support from legally responsible relatives or others, cash receipts, dividends, interest, rents, contributions, and cash benefits from all other sources.

B. *Property and Other Resources:* Property and other resources mean "liquid or marketable assets," exclusive of the following:

1. The applicant's homestead and contiguous real estate.
2. Clothing, household effects, and automobiles.
3. Life insurance having a *cash* value of $1,000 or less.
4. Tangible personal property used in earning income having a fair market value of $1,000 or less.

Allowable Income and Resources

A. *Persons living alone, no spouse or other dependents*

An applicant may be eligible for AMIA when:

1. His total income is not more than $1,800 for the projected 12 months dating from the calendar month immediately preceding the month of application, and *after deducting from that income* amounts necessary to maintain in force his existing medical, surgical, hospital, or other health insurance policies; and
2. The value of his "liquid and marketable assets" does not exceed $1,800; and
3. The cost of his allowable medical needs exceeds that *deductible* portion of his income, in accordance with standards set forth by the Department (See Standard For Payment By Recipient); and
4. The cost of these medical needs is not payable by health insurance covering him as a beneficiary.

B. *Person living with spouse or other dependent*

An applicant may be eligible for AMIA when:

1. The combined total income of the applicant and his dependent does not exceed $2,400 for the pertinent 12 month period, *after deducting from that income* amounts necessary to maintain in force existing medical, surgical, hospital, or other health insurance policy or policies; and
2. The value of their "liquid and marketable assets" does not exceed $2,400; and
3. See #3 above
4. See #4 above

C. *Persons living with more than one dependent*

The applicant may be eligible for AMIA when:

1. The combined total income does not exceed $1,800 for the applicant, plus $600 for each dependent, for the pertinent 12 month period, after deducting from their total income amounts necessary to maintain in force existing medical, surgical, hospital or other health insurance policy or policies; and
2. The value of their combined property or other resources does not exceed $1,800 for the applicant, $600 for the first dependent, plus $400 for each additional dependent; and
3. See #3 above
4. See #4 above

Standard For Payment By Recipient

The amount of medical expenses for which the applicant is responsible is based on income and value of resources and determined by the following standards:

A. *Income Standard:*

Net Income	Amount Payable by Applicant
$1,800	$180
1,700—1,800	156
1,600—1,700	133
1,500—1,600	112
1,400—1,500	93
1,300—1,400	76
1,200—1,300	60
1,100—1,200	0

When determining the amount payable by an applicant with dependents, the County Department deducts $600 for each dependent from the combined total income. When the net income is $1,800 or less, the amount payable by the applicant is determined by the table above. For example:

1. An applicant without dependents and an adjusted net income of $1,800 and non-exempt resources of $1,800 would be expected to pay $180 toward his allowable medical expense.

2. An applicant without dependents and net income of $1199 and non-exempt resources of $1,800 would not be expected to pay toward his medical expense.

3. An applicant with one dependent (spouse) and combined net income of $2,400 and non-exempt resources of $2,400, would be expected to pay $180 toward his medical expense ($2,400 —$600=$1,800; the amount payable on $1,800 is $180).

4. An applicant with one dependent (spouse) and combined income of $1,800 and non-exempt resources of $2,400, would not be expected to pay toward his medical expenses ($1,800— $600=$1,200; the amount payable on $1,200 is $0).

B. *Applicants With Total Income or Other Resources Exceeding Above Maximums.*

1. *When income and/or property or other resources exceed the legal limits as stated above, the applicant may qualify for AMIA when the cost of his allowable medical care cannot be met after applying all income and other resources in excess of the limits set forth above.* For example:

a. Suppose an AMIA applicant living with a spouse has combined gross yearly income of $2,400 and non-exempt assets worth $2,500. On the basis of *income* he would be expected to pay $180 toward his medical expenses. Since his non-exempt assets *exceed* the legal limit by $100, he would also be expected to pay that amount toward his medical costs for a total amount of $280 before AMIA would be available to cover the remainder.

b. Suppose an applicant and spouse have combined yearly income of $2,500 and non-exempt assets worth $1,500. The *income* is $100 in excess of the allowable income of $2,400. Therefore the applicant would be expected to pay $100 plus $180 toward his medical costs before AMIA would be available to cover the remainder.

c. Suppose an applicant and spouse have combined yearly income of $2,500 and non-exempt assets worth $2,500. Income is $100 in excess of the allowable limits and assets are $100 in excess of allowable limits. Therefore the applicant would be expected to pay $200 plus $180 toward his medical costs before AMIA would be available to cover the remainder.

C. *The Same Rules Apply to Single Individuals Whose Income and/or Assets are in Excess of the Legal Limits.*

Other Provisions Relating to Recipients of AMIA

A. *Family Responsibility*

Family responsibility is part of the law and includes sons and daughters and spouse of the applicant.

When it is established by the County Department of Public Aid that the responsible relative is financially able to meet the cost of the allowable medical services, and he fails or refuses to do so, the county department may authorize payment for the necessary medical care and immediately seek to recover that medical expense from the legally responsible relative by initiating legal action.

The amount of the financial contribution for which the relative is responsible is determined by the County Departmnt based on the relative's income, number of dependents and whether or not the applicant lives with the relative. Contributions are based on tables pre-established by the Department and are used in other public aid programs.
For example:

1. Suppose a responsible relative living with his wife and two dependent children has a monthly salary of $430. The man's mother is an applicant for AMIA. Based on a family unit of *four,* the man's minimum monthly contribution to the support of his mother would be $9.

Monthly contributions by a responsible relative varies according to the responsible relative's income, number of dependents, and whether or not the parent lives in the same household. Details pertaining to this provision vary considerably and are determined by the Department of Public Aid at the local level.

B. *Claims Against the Estate of a Deceased Recipient*

The Public Assistance Code of Illinois provides that the Department has a *claim* against the estate of a deceased recipient of AMIA for the total amount of assistance paid. There can be no recovery of this *claim,* however, while the spouse or other dependent(s), as defined by the Department, survive. The law does not permit the state to file a *lien* to protect the claim. Property transfers whithin five years prior to applying for assistance are prohibited to avoid this provision. The estate claim is in keeping with the position that relatives should not benefit from a recipient's estate at taxpayers' expense. This provision is part of the law and cannot be changed by administrative rule.

C. *Choice of Vendor*

The recipient of AMIA has free choice of vendor.

D. *Right of Appeal*

The AMIA applicant or recipient has the right of appeal and may request such at the County Department of Public Aid.

Applications

Applications for hospital care may be made prior to admission to the hospital. Application may also be made while hospitalized. However, payment will be made only for care received during the month of application and for the duration of the hospital stay. Payment will not be made for hospital care received prior to the calendar month in which application is made. For example:

a. Suppose the applicant enters the hospital on February 25 and, while hospitalized, does not make application until March 2. Payment will be made for the month of March and for the duration of the stay, but *will not be allowed for the month of February.*

b. Suppose an application is filed on February 25 and the patient is admitted on March 10. Payment will be allowed for the month of March and for the duration of the stay even though the stay extends into the following months.

c. Suppose an application is filed on February 25 following the patient's release from the hospital. Payment will not be allowed.

The applicant must be alive at the time request for application is made, but the application Form may be completed and signed following the applicant's death. Request for application may be initiated by the physician by telephoning or writing the County Department of Public Aid. Application may be made in person and the Form should be completed by the applicant when possible. If he is too ill or unable to do so, the application Form may be filed on his behalf by a relative and, if there are no relatives, by any person able to furnish necessary information with competence.

Application Forms may be obtained from the County Department of Public Aid (FO-555 "Application for Assistance to the Medically Indigent Aged") and in most cases, hospitals can provide appropriate Forms to hospitalized patients (FO-PP-450 "Source of Medical Information and Request for Assistance to the Medically Indigent").

Action Needed

Effective continuation of AMIA requires close cooperation between those who administer the program and those who provide the services. The public must be made to understand that the program is designed to help only those who need help, not those who simply want help at the taxpayers' expense. Physicians at the local level should endeavor to:

A. Acquaint themselves and the County Medical Society membership with basic procedures, provisions and objectives of the AMIA program, and

B. Arrange a meeting with officials of the County Department of Public Aid and local

hospitals to see what can be done to smooth the administrative machinery when necessary. Every County Society is urged to have an advisory committee to the Department of Public Aid, and to inform the State Society's Headquarters of difficulties or problems encountered at the local level. The County Society is also urged to submit suggested changes in the rules so that the appropriate committee may review and present them to the Department of Public Aid at the appropriate time. Your full cooperation in this program is urgently needed.

Locations of County Departments of Public Welfare*

ADAMS: 640 Hampshire Street, Quincy
ALEXANDER: 1807 Commercial Avenue, Cairo

BOND: 315 W. Oak Street, Greenville
BOONE: 121 Logan Avenue, Belvidere
BROWN: 233 W. South Street, Mt. Sterling
BUREAU: 500 S. Main Street, Princeton

CALHOUN: 308 South County Road, Hardin
CARROLL: Junction Highway 76 & 88. Box 89, Mt. Carroll
CASS: 209 West Second Street, Beardstown
CHAMPAIGN: 405 S. State Street, Champaign
CHRISTIAN: 305 S. Webster Street, Taylorville
CLARK: 625 Archer Avenue, Marshall
CLAY: 316 W. Vandalia Roard, Louisville
CLINTON: First National Bank Building, Carlyle
COLES: 601 Monroe Street, Charleston
COOK: Englewood office, 6125 S. Halsted St., Chicago
Kenwood office, 417 E. 47th Street, Chicago
Madison office, 1955 W. Madison Street, Chicago
Michigan office, 2535 S. Michigan Avenue, Chicago
Midway office, 6317 S. Maryland Avenue, Chicago
Northern office, 4238 N. Lincoln Avenue, Chicago
Oakland office, 628 S. Dearborn Street, Chicago
Southern office, 751 E. 63rd Street, Chicago
Western office, 3209 W. Roosevelt Road, Chicago
CRAWFORD: 201 E. Pine Street, Robinson
CUMBERLAND: Carr Building, Toledo

DE KALB: 134 W. State Street, Sycamore
DE WITT: 114 S. Madison Street, Clinton
DOUGLAS: 101 W. South Central Avenue, Tuscola
DU PAGE: 213 W. Wesley Street, Wheaton

EDGAR: 150 E. Court Street, Paris
EDWARDS: 48 W. Main Street, Albion
EFFINGHAM: 202 N. Banker Street, Effingham

FAYETTE: 231 S. Fourth Street, Vandalia
FORD: 119 West Pells Street, Paxton
FRANKLIN: 114 W. Church Street, Benton
FULTON: 191 W. Lincoln Avenue, Lewistown

GALLATIN: 211 Lincoln Blvd. West, Shawneetown
GREENE: 425 S. 5th Street, Carrollton
GRUNDY: 116 W. Main Street, Box 167, Morris

HAMILTON: 200 S. Locust Street, McLeansboro
HANCOCK: 526 E. Locust Street, Carthage
HARDIN: 6 South Main Street, Elizabethtown
HENDERSON: Schuyler and Fifth Streets, Oquawka
HENRY: 233 S. Tremont Street, Kewanee

IROQUOIS: 107 W. Oak Street, Watseka

JACKSON: 1331 Walnut Street, Murphysboro
JASPER: 106½ W. Washington Street, Newton
JEFFERSON: 414 Main Street, Box 215, Mt. Vernon
JERSEY: 215 S. Jefferson Street, Jerseyville
JO DAVIESS: 310 N. Main Street, Galena
JOHNSON: McCormick Building, Vienna

KANE: 238 Downer Place, Aurora
KANKAKEE: Arcade Bldg., 187 S. Schuyler Avenue, Kankakee
KENDALL: 123 West Hydraulic Street, Yorkville
KNOX: 250 E. Main Street, Galesburg

LAKE: Room 230, 215 W. Water Street, Waukegan
LA SALLE: 417 W. Madison Street, Ottawa
LAWRENCE: 602 N. 12th Street, Box 148, Lawrenceville
LEE: 221 S. Peoria Avenue, Dixon
LIVINGSTON: The Sterry Block, Pontiac
LOGAN: 219 S. Kickapoo Street, Lincoln

McDONOUGH: 124½ N. Lafayette Street, Macomb
McHENRY: Room 201, 111 Dean Street, Woodstock
McLEAN: 603 N. Center Street, Box 613, Bloomington

MACON: 1401 E. Eldorado Street, Decatur
MACOUPIN: 213 N. East Street, Carlinville
MADISON: 118 Hillsboro Avenue, Edwardsville
MARION: 214 N. Locust Street, Centralia
MARSHALL: 319 Edward Street, Henry
MASON: 323 W. Main Street, Havana
MASSAC: 209 W. 7th Street, Metropolis
MENARD: 117 N. 7th Street, Petersburg
MERCER: 131 W. Main Street, Aledo
MONROE: 113 S. Main Street, Waterloo
MONTGOMERY: 210 E. Fairground Avenue, Hillsboro
MORGAN: 205 W. State Street, Jacksonville
MOULTRIE: 10 S. Worth Street, Sullivan

OGLE: 200 W. Washington Street, Oregon

PEORIA: Room 100, 414 Hamilton Blvd., Peoria
PERRY: 316 E. Franklin Street, DuQuoin

*Prepared by the
Division of Economics and Insurance
Illinois State Medical Society

PIATT: 108 E. Washington Street, Montieello
PIKE: Amerieaη Legion Building, Pittsfield
POPE: Anderson Building, Coleonda
PULASKI: 1st Floor, 212 First Street, Mounds
PUTNAM: Hynds Building, Room 8, Granville

RANDOLPH: 207 W. Holmes Street, Chester
RICHLAND: 426 S. Whittle Avenue, Olney
ROCK ISLAND: 3790 11th Street, Roek Island

ST. CLAIR: 417 Missouri Avenue, East St. Louis
SALINE: 1 W. Elm Street, Harrisburg
SANCAMON: 628 E. Adams Street, Springfield
SCHUYLER: 213 W. Washington Street, Box 111, Rushville
SCOTT: 128 W. Cherry Street, Winehester
SHELBY: 256½ E. Main Street, Shelbyville
STARK: 104 S. East Street, Toulon

STEPHENSON: 27-29 West Main Street, Freeport

TAZEWELL: 530 Margaret Street, Pekin

UNION: 110 Lafayette Street, Anna

VERMILLION: 309 N. Franklin Street, Danville

WABASH: 220 Market Street, Box 149, Mt. Carmel
WARREN: 105 N. Main Street, Monmouth
WASHINCTON: 101a S. Kaskaskia Street, Nashville
WAYNE: 103 E. Main Street, Fairfield
WHITE: 304 E. Robinson Street, Carmi
WHITESIDE: 219 E. Main Street, Morrison
WILL: 57 W. Jefferson Street, Room 201, Joliet
WILLIAMSON: 606 N. Van Buren Street, Marion
WINNEBACO: Room 400, 526 W. State St., Roekford
WOODFORD: 107 N. Major Street, Eureka

Occupational Health—*A New Challenge to Illinois Physicians*

The terms *Occupational Medicine* and *Occupational Health* are used to describe what we formerly knew as "Industrial Medicine" and "Industrial Health." These better, newer terms are more inclusive. They encompass the health of *all* employed persons—not industrial workers alone.

Prior to 1920, injuries arising from employment in railroads, steel works, foundries, mines, factories and construction jobs constituted the major responsibility of industrial medicine and surgery. During the past 40 years, however, the number of occupational injuries has been markedly reduced. The work of the National Safety Council, the functioning of safety committees, and the activities of industrial plant medical departments have contributed greatly to this reduction of occupational injuries.

During this same period, the work of industrial medical departments has expanded to include proper employee placement and health maintenance. Preplacement physical examinations ensure proper work assignments. They also reveal many previously unknown pathological findings. For example, twenty per cent of all hernias found are not known to the applicants prior to their preplacement physical examinations. Diabetes, hypertension and early chest lesions are some of the other findings revealed on periodic health examinations. Health maintenance includes adequate industrial hygiene studies which result in measures that protect workers from occupational health hazards.

Maximum mental and physical well being is the goal of the occupational health program. With this aim in view, there is a tremendous challenge to all physicians in Illinois to participate in its programs. There is a correct, proper and ethical way to practice medicine in the field of occupational health. The purpose of the ISMS Occupational Health Committee, in cooperation with the county medical society committees on occupational health, is to initiate interest and to foster the development of occupational health programs—including part-time medical services to small plants and medical departments of larger industries—in all communities in the State.

The ISMS Occupational Health Committee includes the following physicians:

Edward C. Holmblad, M.D., Chicago,
Chairman
Arthur S. J. Peterson, M.D., Chicago
Milton H. Kronenberg, M.D., East Peoria
O. W. Rest, M.D., Chicago
Edward A. Razin, M.D., Berwyn
Fred Stansbury, M.D., Galesburg
Myron J. Tremaine, M.D,. Chicago
Chester R. Zeiss, M.D., Chicago
Ex-Officio:
Henry F. Howe, M.D., Chicago

Doctor Cole Describes Aim of Medical Education

"Broadly speaking, the aim of a medical education is to produce a good doctor . . . unfortunately, we do not know the definition of a 'good doctor.'"

This statement was made on the night of January 16, 1964, by Dr. Warren H. Cole, Professor of surgery and head of the Department of Surgery at the University of Illinois College of Medicine in Chicago, in his presidential acceptance address before the Chicago Institute of Medicine.

Speaking on *Education: Its Values, Obligations and Responsibilities*, Dr. Cole said only the amount of money a doctor makes and his contributions to medicine can be measured with any degree of accuracy. However, "these two quite certainly are less important than other intangibles such as the standard of his medical practice."

"Therefore," continued Dr. Cole, "we as teachers are striving to produce a good doctor, but have only a very faint image of what he should look like."

He pointed out that some schools emphasize training general practitioners; and "some believe we should develop a curriculum which would encourage our students to take up research careers," while others stress developing of specialists.

While no school should encourage all of its graduates to restrict themselves to one of these three activities, it also appears logical "that state universities might concentrate more on the development of practitioners of medicine, whereas some of the endowed universities might place emphasis on development of graduates primarily interested in research."

Speaking on the possible need for more physicians, Dr. Cole said that "until a few years ago most groups, including the AMA and practically all other groups, expressed the opinion that there were enough physicians. However, the AMA and almost all other groups now agree that we should graduate more physicians."

"The scarcity of physicians for government jobs available cannot be considered an index of scarcity, because such a scareity might be artificial, dependent upon the development of a certain project which might not appear to have justification from the standpoint of health welfare. Actually, the answer to the question would be much more valid if it were based on distribution of work."

Turning to problems of the medical student, Dr. Cole said that "we have an argument amongst medical educators insofar as many educators say we are wasting the student's time by asking him to learn facts, contending we should spend our time teaching him the ability to correlate. Here they lose me because I do not understand how correlation can be carried out unless one has some facts to correlate."

"The student," explained Dr. Cole, "must know and remember the symptoms and signs of appendicitis, acute pancreatitis, perforating peptic ulcer, etc., if he is going to be able to differentiate these lesions . . . and make an accurate diagnosis."

In conclusion, Dr. Cole cited two urgent needs in medical education.

"The greatest (of the needs)," he said, "is to have more clinicians obtain a Ph.D. or equivalent, and to have more Ph.D.s in the medical programs obtain an M.D."

"The gap between the M.D. and the Ph.D. is too big. It is so big that, in my opinion, many inefficient and unfair decisions or actions have been dispensed or administered."

Suggesting that this problem can be solved by individual effort, Dr. Cole pointed out that the Department of Surgery at the University of Illinois has had three of its last six surgical residents begin graduate training toward a Ph.D.

The second urgent need discussed by Dr. Cole related to subsidy for education.

"We recognize the great need for subsidy for education," he said, "and we are happy to say sizable sums have been allocated by various governmental agencies . . . on the other hand, we must recognize the frankly disgraceful fact that comparatively little money is allocated to education, and practically none for research in medical education."

You Can Lead a Horse to Water, But . . .

The conclusions of the advisory committee to the Surgeon General on smoking and health were not surprising. For some time there has been mounting evidence linking heavy cigarette smoking to coronary artery disease, circulatory disorders, chronic bronchitis, lung cancer, and emphysema. The lung cancer rate is 10 times what it was 30 years ago, killing 41,000 Americans last year. It is not easy to exonerate tobacco when most of our patients with bronchogenic carcinoma are heavy smokers.

But this is just the beginning. Attacks on tobacco go back to the 16th century and to date none have been successful. Our modern campaign must buck an 8 billion dollar industry and 70 million smokers. The attitude of the medical profession will carry considerable weight as to the acceptance of the report by the public. Many physicians will refuse to accept the facts, especially those who smoke. Perhaps they must save face or they have never read the medical literature on this subject. They prefer to follow the now stale line of reasoning of the tobacco industry that repeats over and over "this proves nothing" or "more research is needed."

What next? The least we can do is to acquaint our patients with the risk involved and let them decide. The teenager should be discouraged from starting to smoke because it is difficult to stop after the habit is well established. In addition, those who start smoking early in life are more likely to develop the diseases mentioned because they smoke more cigarettes per day over a longer period of time.

Many authorities believe reforms are needed in cigarette advertising and promotion. They want labels on the package or dispenser to contain informative material, urging caution, as is done with many other hazardous products. It is here that the government may take a stand.

Meanwhile, tobacco withdrawal clinics will be organized. They are proving to be successful in Europe and may be of help in Illinois. Determination and motivation are the best aids along this line.

T. R. Van Dellen, M.D.

The View Box

—diagnosis and discussion

(Continued from page 135)

Diagnosis: Ascariasis

There are characteristic changes in the X-rays due to the presence of intestinal ascaris. The appearance depends on the displacement of some of the barium mixture by the worms, producing cylindrical filling defects, as seen to the right of L3 and overlying the left iliac crest in Film 1.

A later film shows the linear tract worms either coated externally with barium or possibly ingested into the enteric canal of the worm. Film 2 (mid-abdomen)

X-ray examination is particularly helpful in the diagnosis of ascariasis when few female worms are present and few or no ova are expelled in the feces.

Looking for a Place to Practice? Placement Service Lists Openings

The *Journal* periodically publishes synopses submitted by various Illinois towns that need physicians. Listed below are a number of such synopses.

MERCER COUNTY: Aledo; population 3200. Estimated population of trade area: 16,000. Several small towns in trade area without physicians. 4 practicing physicians, ages 67, 65, 55 and 48. Need for two additional general practitioners. Mercer County Hospital located here. 30 miles from quad cities—Rock Island, Moline, East Moline, Illinois and Davenport, Iowa. 2 prescription drug stores. Ambulance service provided by local funeral home. Adequate office space and housing available. Sources of income: industry and argriculture. Churches: Catholic, Methodist, Baptist, Lutheran, United Presbyterian and Assembly of God. 2 grade schools; 1 high school. Roosevelt Military School located here. Nearest college at Monmouth, 30 miles. Organizations: Mercer County Historical Society, Kiwanis, Jr. Chamber of Commerce, Rotary, etc. Oakview Country Club and Golf course, swimming pool and park. For further information contact:

M. E. Conway, M.D., President, Mercer County Medical Society, 403 S. E. Second Avenue, Aledo, Illinois. Phone JU 2-2411.

MONTGOMERY COUNTY: Witt: population 1000. No resident physician. Nearest physicians at Nokomis, Pana and Hillsboro, 5, 18 and 12 miles. Nearest hospital at Hillsboro, 12 miles. Nearest large city, Decatur, 50 miles; population 60,000. Ambulance service provided by local funeral home. Witt Lions Club has initiated a program to build a new office building to be rent free for some time. Agricultural area. Churches: Christian, Methodist, Presbyterian, Pentecost and Catholic. Grade and high school. Nearest college at Greenville, 40 miles. Active Lions Club and American Legion. Recent survey by Sears Foundation reveals "estimated expenditures over a 12 month period for medical care based on office calls only"—$31,535. For further information contact:

Mr. Maurice F. Stauder, Box 407, Witt, Illinois. Phone Witt 2951; or Reverend R. T. Shea, St. Barbara's Rectory, Witt, Illinois.

McLEAN COUNTY: McLean; population 700: only local physician moved to specialize in radiology. Nearest physicians at Bloomington, 15 miles, and Atlanta, 4 miles. Nearest hospitals at Bloomington. 45 minutes from Springfield, Illinois. Local prescription drug store. Office space: six room office remodeled last year, located in business district on ground level. Office equipment of former physician for sale or rent. Local contractor will guarantee new house for rent or sale. Financial assistance could be provided if desired. Agricultural community. Churches: Methodist, Christian and Church of God. Grade and high schools. Nearest college at Bloomington, 15 miles. Organizations: Masonic Lodge, Eastern Star, American Legion and Auxiliary, Civic Club. For further information contact:

Mr. Dean Walters, Box 115, McLean, Illinois. Phones 874-3411 or 874-3511.

MONROE COUNTY: Valmeyer; population 720. 1 physician, aged 63. Estimated population of trade area, 2500. Nearest additional physicians, 10 miles. Nearest hospitals at Red Bud, 24 miles; and East St. Louis, 28 miles. 30 miles from St. Louis, Missouri. Ambulance service provided by 2 funeral homes. Comparatively new office for rent; modern waiting room, examining room and X-ray room. Houses for sale and for rent. Financial assistance for physician could be arranged if desired. Many residents of German descent. Sources of income: agriculture, quarry, mushroom growing, oil pumping station, elevators. Churches: United Church of Christ, Catholic and Baptist. Grade and high schools. Organizations: American Legion and Auxiliary, Optimist International, Woman's Club, PTA, church organizations, etc. Nearest country club at Waterloo, 10 miles. Nearest swimming pool, 12 miles. For further information contact:

Mrs. Gladys Niebruegger, Valmeyer, Illinois.

OGLE COUNTY: Leaf River; population 550. 765 additional people with rural route addresses from Leaf River. 160 families in nearby Egan. Nearest hospitals at Freeport and Rockford, each 20 miles away. Nearest doctors at Mt. Morris and Byron, each 7 miles away. Leaf River on highway 72. Four room office of deceased physician for rent. **Rent free first year.** Housing available. Agricultural community. Many employed in nearby factories. Churches: Brethern, Congregational, Christian, and Methodist. New $200,000 grade school; community high school. Organizations: Womans Club, Legion Auxiliary, Boy and Girl Scouts, Lions, etc. New $300,000 recreation center includes swimming pool, community hall, meeting rooms, etc. Nearest golf course at Mt. Morris, 7 miles. Good all weather roads. Milwaukee Railroad. For further information contact:

Mr. John Wagner, Mayor, Leaf River. Mr. W. F. Light, supervisor, Leaf River.

PEORIA COUNTY: Princeville; population 1300. Several nearby towns without physicians. One local physician; need for a second due to deaths of other two local physicians. Nearest hospitals at Peoria, 25 miles; population 115,000. Plans for a new hospital in Chillicothe, 15 miles away. One local drug store. Newly

(Continued on page 166)

protect patients adversely affected by cold air

Weather-Guard

Heat· Mask

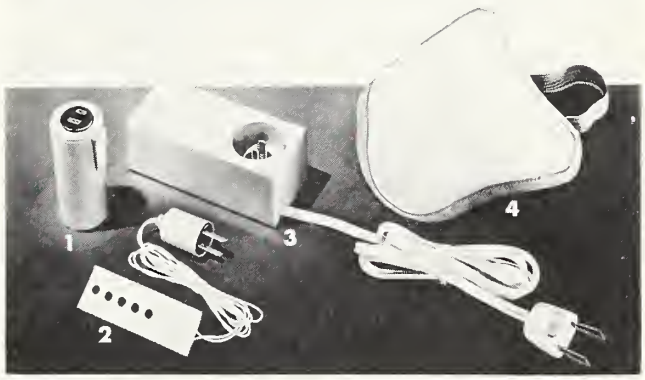


PREHEATS INHALED AIR to reduce ill effects caused by the inhalation of cold air in patients with: CORONARY INSUFFICIENCY • ASTHMA • COLD ALLERGY • EMPHYSEMA • SINUSITIS • BRONCHITIS. (Increases comfort for outdoor workers and sportsmen during cold weather.)

THE ONLY ELECTRICALLY HEATED MASK. *Durable* enough to protect from cold winds. *Sufficiently porous* to insure correct CO_2-0_2 exchange. *Completely washable* for proper hygiene and avoidance of reinfection.

DESIGNED BY A PHYSICIAN—clinically proved in thousands of cases.

Parts consist of: (1) Nickel-cadmium rechargeable battery, fits into pocket, provides up to 3½ hours of continuous use (2) Heating element (3) Battery recharger, plugs into 110 V. AC outlet and (4) Mask, of soft, porous, hypoallergenic dacron material.



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Adult size _____ Children's size _____

IMPORTANT: Indicate quantity for patient use _____ Personal use _____
Enclosed is my check for _____

Name _____ M.D.

Address _____

☐ Please send a quantity of patient order forms and literature

(Continued from page 164)
remodeled downtown office with six month's free rent. Will alter to doctor's specifications. Houses for sale and for rent (selling price $8,000 to $12,000). Financial assistance to new doctor could be arranged. Sources of income: agriculture, 3 factories and 3 rock quarries. Churches: Methodist, Presbyterian, Catholic, Apostolic Christian and Church of Christ. Grade school and new high school. Nearest college at Peoria—Bradley. Organizations: Kiwanis, VFW, American Legion and Community Council. Recreational facilities: Country club with pool and golf course, 8 miles. Below-average real estate taxes. For further information contact:

William M. German, President, Princeville Chamber of Commerce, Princeville, Illinois. Phone: 385-4757.

PIKE COUNTY: Perry; population, 450. Only physician died recently. Nearest physicians at Meredosia, 10 miles, and Pittsfield, 16 miles. Nearest hospital at Pittsfield (Illini Community, 40 beds). Physicians who have filed intention of citizenship eligible for hospital staff. 48 miles from Quincy. Ambulance service provided by funeral home. Good roads. Office space and housing facilities available. Financial assistance could be arranged if desired by physician. Agricultural community. Churches: Methodist, Presbyterian, and Church of Christ. Grade and high schools; nearest college at Jacksonville, 32 miles. Organizations: Masonic Lodge, Eastern Star, Farm Bureau, Home Bureau, American Legion, etc. Recreational facilities at Nearby Pittsfield. For further information write to:

Mrs. Mervin Woods, Perry, Illinois.

PULASKI COUNTY: Karnak; population 792; estimated population of trade area, 3,000. Nearest hospital at Metropolis, 20 miles. Nearest city, Paducah, Kentucky, 30 miles; population 30,000. No drug stores. Ambulance service provided by local funeral home. Paved roads, 2 state roads and one U.S. route. Local Lions Club will raise an $8,000 Loan Fund for a physician to draw from and for a modern house and office to rent and if possible option to buy. Sources of income: agriculture and lumbering. 6 churches, Protestant and Catholic. Grade and high schools. Nearest college, 50 miles; Southern Illinois University. Nearest country club, 20 miles at Mounds. For further information contact:

Mr. Allen Main, Karnak, Illinois; Mr. Curtis Cummins, Karnak, Illinois; or G. J. Meshew, M.D., Mounds, Illinois.

RANDOLPH COUNTY: Prairie du Rocher; population, 700; estimated population of trade area, 4,000. No resident physician. Nearest physician and hospital at Red Bud, 12 miles; St. Clement's Hospital, 63 beds. Nearest city, Belleville, 32 miles. Missouri Pacific railroad. Adequate office space and housing. Predominant nationality: French. Agriculture community. Local stone quarries employ about 225 men. Near the future location of a Kaiser Aluminum Plant. Catholic and Baptist churches. Grade and high schools. Nearest college at Belleville. Active American Legion. Natural gas. State Park four miles from town. Located on a scenic river highway. For further information contact:

Mr. Arnold R. Mudd, Mayor, Prairie du Rocher, Illinois.

ROCK ISLAND COUNTY: Opening for a general practitioner. 125 physicians in county, including 17 general practitioners. Hospitals: St. Anthony's, Moline Lutheran and Moline Public. Citizenship required for hospital staff membership. Office space and housing available. Primary source of income; farm implement. Protestant, Catholic and Jewish churches. Grade and high (4) schools. Three colleges in area. Recreational facilities: country clubs, golf courses, swimming pools, etc. For further information contact:

T. Grevas, M.D., 213 Safety Building, Rock Island, Illinois. Phone: 788-0467 or L. Martin, M.D., 1630 Fifth Avenue, Moline, Illinois.

STARK COUNTY: Toulon; population 1213. 1 physician, aged 72. Nearest additional physician at Wyoming, 6 miles. Nearest hospitals at Kewanee, 14 miles; St. Francis and Kewanee Public; citizenship required for staff membership. 40 miles from Peoria with 3 hospitals. 2 local drug stores with registered pharmacists. Good roads. 3 state routes. Office space and housing available. Agricultural community. Kraft factory located here. Churches: Baptist, Methodist, Congregational, Catholic and Christian Science. Grade and high schools. Organizations: VFW, Chamber of Commerce, Lions, American Legion, Masons, Odd Fellows, Musical Club, Womans Club, etc. Nearby country clubs at LaFayette and Kewanee. For further information write to:

Mr. Gerald C. Stapel, President, Chamber of Commerce, Toulon or Mr. J. Merlyn Kidd, Toulon.

TAZEWELL COUNTY: Morton; population 5300. Physician needed to replace Cody Cox, M.D., deceased. Nearby physician in his office on a "part time" basis. Three additional physicians. Nearest hospitals at Peoria, 12 miles: 10 minute drive by express highway. Population 103,000. 2 local drug stores. Description of office: brick Dutch colonial home converted to office; two car garage; second floor vacant at present; on main street of town; lawyer and dentist next door. Doctor Cox's equipment available if desired; includes, X-ray, basal, EKG, diathermy, lab, office equipment, etc. Many residents employed at Caterpillar Tractor and Hiram Walker in Peoria. Churches: Community, Catholic, Baptist, Lutheran, Christian Apostolic, Mennonite and Christian. Public and parochial grade schools. Local high school. Nearest college, Bradley at Peoria. Organizations: Optomist, Lions, J. Cs. Chamber of Commerce, Womans Club, PEO, etc. Swimming pool was constructed in summer of 1963. Nearby Country Club. Opening verified by local medical society. For further information contact:

Mrs. Cody Cox, Route 1, Lynnwood Court, Morton, Illinois. Phone 265-6081.

Constant diagnostic and cardiac distress information around the clock — with immediate alarm if irregularities in heart rhythm occur — are automatically provided by this new Sanborn *Viso-Monitor*. This compact, integrated bedside system — for recovery room, intensive care or OR use — includes a built-in electrocardiograph, pacemaker, cardiotachometer and eight illuminated alarm indicators.

Your patient's ECG is recorded automatically for 10 seconds at either pre-set intervals or at the onset of any of four distress conditions. It can also be taken *during pacing*, for valuable knowledge of the patient's response to pacing. *Heart rate* is continuously displayed on the front panel meter, which has adjustable upper and lower thresholds to activate alarms. *Bradycardia, tachycardia, peripheral pulse loss, arrest* and each *QRS complex*, as well as operating conditions of the Viso-Monitor, are shown by warning lights. *Internal or external pacemaking current* is provided by the instrument, with adjustments for current and rate and positive safeguards to prevent accidental pacing. *Audible alarm* is supplied by an optional Remote Alarm unit, which also duplicates visual indicators and heart rate meter of main instrument. The new Model 780 Viso-Monitor is $1850, the Remote Alarm unit $250, and DC Defibrillator $1370 (F.O.B. Waltham, Mass., continental U.S.A.).



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Rx Review

Ceo-Two: An effective, convenient replacement of the liquid enema in convalescent and geriatric patients. This original, effective, non-irritating, carbon-dioxide-generating, evacuant suppository is specifically designed for the treatment and correction of constipation.

Manufacturer: Beutlich, Inc., Chicago 45, Illinois.

Description: Each 6.7 gram suppository contains: Sodium bicarbonate in a water soluble polyethylene glycol base buffered to pH 7.0. Ceo-Two is available in packages of 10 suppositories. No refrigeration is required.

Indications: Pre and post partum; pre and post operatively; for proctoscopic and X-ray examinations; whenever the last 25 cm. of the lower bowel must be emptied. If defecation does not occur within 30 minutes, bowel is usually void of fecal matter.

Dosage: One Ceo-Two suppository is usually sufficient to induce defecation. *For most effective results:* Moisten slightly with water. Patient should retain suppository as long as possible. Do not use mineral oil or petrolatum as lubricant. *Should be used following a meal.*

Advantages: Safe, does not irritate or gripe. No danger of solutions being introduced under pressure. Non-habit-forming. Convenient, easily carried for use during house calls. Less expensive to patient and hospital than liquid enemas.

Contraindications: As with other enemas or laxatives, there are no known side effects.

Literature and samples sent on request.

Quinidex® Extentabs® (brand of quinidine sulfate) (formerly marketed as Quinidex L-A by Whittier Laboratories, Division of A. H. Robins Company).

Manufacturer: A. H. Robins Company, Inc., Richmond, Virginia.

Description: Each Extentab contains quinidine sulfate, 300 mg.

Indications: For the control of cardiac arrhythmias, as in paroxysmal atrial tachycardia, paroxysmal nodal tachycardia, auricular flutter, auricular fibrillation, ventricular tachycardia, frequent ventricular extrasystoles (in some cases), and prophylactically following myocardial infarction (to prevent arrhythmia).

Dosage: Two Quinidex Extentabs (quinidine sulfate) every 8 to 12 hours.

Precautions: All the precautions applying to regular quinidine therapy apply to the Extentab form. Use with care in patients with severe congestive failure or with digitalis intoxication. Patients should be carefully observed for signs of toxicity; e.g., (1) allergy or idiosyncrasy, such as febrile reactions, skin eruptions, and thrombocytopenia (extremely rare); (2) "cinchonism" (tinnitus, blurred vision, dizziness, lightheadedness, and tremor); (3) G-I symptoms (nausea, vomiting, diarrhea, and colic); (4) cardiotoxic effects such as ventricular extrasystoles occurring at a rate of one or more every 6 normal beats, an increase of the QRS complex of 50 per cent or more, a complete A-V block, or ventricular tachycardia.

Contraindications: Intraventricular septal defects. A-V block. Idiosyncrasy.

Packaging: White, coated, extended-action tablets, marked "Robins," in bottles of 30 and 250.

Pregnosticon® (Immunodiagnostic Pregnancy Test), a new laboratory test on urine that detects pregnancy as early as eight days after menstruation fails to occur. Organon Inc., West Orange, New Jersey, has developed this new product. This highly simplified test is performed without laboratory animals and requires only ordinary equipment. Procedures such as centrifuging and incubation are unnecessary. The test can be set up in less than three minutes and results read easily and rapidly within two hours. In extended clinical trials, results with PREGNOSTICON have been consistently accurate.

Advantages: Investigators see the early accuracy of the PREGNOSTICON test as an outstanding advantage over the older animal and oral hormone tests. With animal tests, accurate results are not possible until about the fortieth day of gestation. The oral hormone tests, in addition, require a waiting period of some five to fifteen days after medication stops.

The new test permits very accurate and earlier detection of pregnancy, especially important prior to elective surgery or before initiating therapy with certain types of drugs.

Features: The *Pregnosticon* test involves an immunologic reaction employing antigenantibody agglutination, and is based on a precisely measured sensitivity to human chorionic gonadotropic hormone (HCG) which is present in urine during pregnancy.

Sharp, easily read endpoints are a major feature of this test. If the urine tested is from a pregnant woman, a brown, doughnut-shaped ring pattern appears within two hours in the bottom of the test tube (positive test). If the urine is not from a pregnant woman, only a diffuse sediment is seen (negative test).

Availability: Pregnosticon is made available to laboratories in a 20-test kit with a special mirrored test rack which facilitates reading results.

an ironclad case against anemia*



Heptuna® Plus

arms your patients to fight anemia due to deficient iron intake and loss of blood.

Its formula has been improved 6 times in 12 years to reflect findings of proven nutritional importance in oral therapy of hypochromic microcytic anemias.

Current Formula

Ferrous sulfate	340 mg.
Iron (from ferrous sulfate)	100 mg.
Desiccated liver, N.F. (undefatted)	50 mg.
Vitamin C (from sodium ascorbate)	150 mg.
Vitamin B_{12} (as Stablets®) with intrinsic factor concentrate (noninhibitory)	½ N.F. oral unit†
B_1 (thiamine mononitrate, U.S.P.)	3 mg.
B_2 (riboflavin, U.S.P.)	2 mg.
B_6 (pyridoxine hydrochloride, U.S.P.)	2 mg.
Niacinamide, U.S.P.	15 mg.
Calcium pantothenate, U.S.P.	1 mg.
Cobalt (from cobalt sulfate)	0.1 mg.
Copper (from copper sulfate)	1 mg.
Molybdenum (from sodium molybdate)	0.2 mg.
Calcium (from dicalcium phosphate)	37.4 mg.
Iodine (from potassium iodide)	0.05 mg.
Manganese (from manganese sulfate)	0.033 mg.
Magnesium (from magnesium sulfate)	2 mg.
Phosphorus (from dicalcium phosphate)	29 mg.
Potassium (from potassium sulfate)	1.7 mg.

*Hypochromic microcytic anemia.
†Potency established prior to mixture with other ingredients. Stablets, U. S. Pat. No. 2,830,933.

Precautions and Side Effects: Because some patients with pernicious anemia do not respond to oral Vitamin B_{12}, they should be followed with periodic laboratory studies. Anemia is a manifestation of an underlying disease and it is necessary to make an etiological diagnosis. In a small percentage of patients, iron therapy causes gastrointestinal irritation. In these patients, administering Heptuna Plus with meals or reducing the dosage usually will alleviate the symptoms.

Supplied in bottles of 100 capsules. Rx only.

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Reduction of Measles Vaccine Side Effects

Dramatic reduction in the incidence of undesirable side effects which often follows administration of live measles vaccine can be obtained by previous administration of killed vaccine, it was reported at the annual meeting of the American Medical Association in June.

The report was in the form of a scientific exhibit by Louise W. Rauh, M.D., and Rosemary Schmidt, M.D. of the Medical College, University of Cincinnati.

Dr. Rauh and her associate centered their studies around the use of three doses of 0.5 ml of inactivated measles virus vaccine administered alone, administration of one dose of 1.0 ml of killed vaccine followed by one dose of live vaccine, and two doses of 0.5 ml of killed vaccine followed by one dose of live vaccine. All injections were given at monthly intervals.

In the study in which killed vaccine alone was used, 80 measles susceptible children received three monthly doses of killed vaccine. Blood samples were taken one month after the third injection and all 80 children were found to have detectable antibodies.

From this, the researchers concluded that the inactivated vaccine has "adequate antigenicity". They noted "extremely mild" side effects comprised of fever and irritability in 5 per cent of the children.

Administration of combinations of killed and live vaccine was conducted in three dosage regimens. In the first regimen, a single dose of 0.5 ml of killed vaccine was administered one month before an injection of live vaccine. The clinicians found that 19 of 27 children showed significant reaction to the live vaccine, or a reaction rate of 70 per cent.

In the second regimen, one dose of 1.0 ml of killed vaccine preceded administration of live vaccine. Of 21 children, three showed significant reaction for a rate of 14 per cent.

In the third approach, two injections of killed vaccine were administered to 35 children prior to injection of live vaccine. None showed any significant reaction to the live vaccine.

The researchers concluded that "sensitization with inactivated vaccine using either one dose of 1.0 ml or two doses of 0.5 ml, dramatically reduces the undesirable side effects which usually follow the administration of live attenuated vaccine."

Not enough time had elapsed, the researchers pointed out, since inception of the study to determine the persistence of antibodies. However, they add, "from recent data published by Fulginiti et al and Guinee, the KKL schedule seemed to offer equal and possibly better protection than either of the studies using K or L alone."

They concluded that "If as available evidence seems to point out, the reaction rate can be so reduced and the protection rate significantly increased, then the combined administration schedules would appear to offer the most acceptable and effective means of controlling measles."



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NEWS and ANNOUNCEMENTS

AMA-ERF Check Presented To Stritch School of Medicine



From left to right, the chairmen of the department of Stritch School of Medicine are: Dr. Peter Talso; Rev. John W. Bieri, S.J.; Dr. Walter Randal; Dr. James Callahan; Dr. Frederick Selfridge; Dr. Alexander Karczmar; Dr. John F. Sheehan, Dean of Stritch School of Medicine; Dr. Arkell M. Vaughn, chairman of committee on AMA-ERF; Dr. Benjamin Orndorf; Dr. E. A. Piszczek, president-elect, IMS; Dr. Gissur Brynjolfsson; and Dr. Lincoln Domm.

A CHECK for $39,568.82 was presented to Stritch School of Medicine Dean Dr. John J. Shechan (standing left) by Dr. Arkell M. Vaughn, Chairman of the Illinois State Medical Society's American Medical Association Education and Research Fund Committee during a brief ceremony at the School last month.

The money is allocated from the ISMS dues structure to provide loans for unrestricted use by the deans.

In addition, the AMA-ERF Committee presented checks to Northwestern University School of Medicine; Chicago Medical School; University of Chicago School of Medicine; and University of Illinois College of Medicine totalling more than $150,000.

Over the past 13 years the Illinois State Medical Society, through this fund, has allocated nearly $2 million for medical schools to lead all other states.

PULSE of the Illinois State Medical Society

February, 1964 *A Service of the Public Relations Division*

New Committee to Stimulate Public Affairs

The Board of Trustees approved formation of a Committee on Public Affairs January 11 to "encourage active participation in public affairs by Illinois physicians and their wives."

Specific activities of the new, 24-member committee will include:

1. Establishment of Public Affairs Committees at the county level.

2. Publication of a bi-monthly newsletter, apprising the entire ISMS membership of the latest issues in public affairs.

The Committee will also offer guidelines of operation for the county committees and institute—in conjunction with the county committees—public affairs programs held at the congressional or medical society district level.



DR. JOHN A. NEWKIRK
New PA Committee Chairman

Newly appointed chairman Dr. John A. Newkirk, Elgin, is former chairman of the Illinois Medical Political Action Committee. "By concentrating on public affairs education," Dr. Newkirk said, "the new committee will complement the candidate-sponsoring activities of IMPAC."

First activity of the Committee was the Public Affairs Conference in Washington, on which it worked with the ISMS Legislative Committee. Held during the first week of February, the conference brought together Illinois physicians and their wives with our national representatives.

Plan Drive to Bar Teen Smoking

A resolution calling for an "aggressive and continuing education campaign to prevent children from starting the smoking habit and to influence teen-age smokers to discontinue the habit" was passed by the Board of Trustees January 12.

Dr. John L. Reichert, Board Trustee and Acting Chairman of the ISMS Child Health Committee which sponsored the resolution, said that details of the campaign will be worked out with "all who are interested in children and teen-agers."

Immediate consequences of this resolution and the government report on smoking were Board proposals that 1) the Illinois Medical Journal refrain from carrying further cigarette ads and that 2) no exhibit space at the annual convention be sold to cigarette companies. The Committee on Scientific Assembly and the Journal Committee are to report their recommendations on these proposals to the Board for action.





Propose Health Center

The expanding concept of the "health team" in Illinois—coupled with the unsurpassed medical facilities in Chicago—could lead to the establishment here of an Environmental Health Center as proposed by the U. S. Public Health Service.

President Elect Dr. E. A. Piszczek made this pronouncement to the Board of Trustees Janary 11, adding that the deans of medical schools and schools of engineering in the Chicago area were developing a "white paper" which described the advantages of Chicago as the site for this center.

IN APPRECIATION

ISMS past trustees were honored by the Board of Trustees Jan. 11 for their outstanding service to the society. Recipients of traditional plaques are, from left: Dr. E. A. Piszczek, third district; Dr. Jacob E. Reisch, fifth district; and at far right Dr. Ted LeBoy, third district, receiving plaque from B. E. Montgomery, ISMS Finance Committee Chairman. Fourth recipient, Dr. W. W. Fullerton, tenth district, is not pictured.

COUNTY CAPSULES

★ ★ ★

DUPAGE COUNTY Medical Society has installed Dr. C. Perkins, West Chicago, as president; and Dr. J. M. Stoker, Elmhurst, vice president. Dr. Charles Lang was re-elected as secretary-treasurer.

★ ★ ★

JACKSON COUNTY hosted a symposium on Fetus and Newborn presented by the ISMS Child Health Committee January 16 at the University of Southern Illinois in Carbondale. First such symposium sponsored by the Child Health Committee's newly formed Subcommittee on Fetus and Newborn, the event attracted more than 60 physicians and nursing department heads from the entire southern area of the state.

★ ★ ★

MORGAN COUNTY will be host to physicians and laymen from 37 counties in Illinois who will attend a conference on "Nutrition and the Heart" Feb. 27 in Jacksonville. Purpose of the conference—sponsored by the Illinois State Medical Society and Illinois Heart Association—is to clarify the relationship of nutrition to heart disease. Principal speaker will be Dr. George V. Mann, Career Investigator for the National Heart Institute at Vanderbilt University in Nashville, Tenn. Dr. Mann will speak during the evening session on "An Illustrated Tour of Central Africa—Cross-Cultural Studies of Coronary Disease." During the afternoon session he will speak on "Epidemiological Aspects of Diet and Heart Disease."

★ ★ ★

SANGAMON COUNTY Medical Society has installed Dr. Henry F. Berchtold as 1964 president; and Dr. Edwin A. Lee, new vice president. Dr. William DeHollander is the new secretary-treasurer.

10 Points Pinpoint M.D. Image, Set Pattern for PR Programs

TEN ESSENTIAL CHARACTERISTICS by which the public should come to know the Illinois physician better have been established by the ISMS Public Relations Committee.

"This unique achievement gives us a permanent, concise pattern for improving and maintaining the physician's image with all segments of the public," declared PR Committee Chairman Dr. Leo P. A. Sweeney.

The 10 points—approved by the Board of Trustees January 12—are:

1. That the physician's first concern is for the well being of his patients, regardless of remuneration.
2. That he strives to improve his professional skills through continuing education.
3. That he is morally obliged to keep the public informed on all health matters.
4. That he is obliged to protect the public from fraudulent and unethical practices.
5. That he is an active force in determining and planning health services and payment for these services.
6. That he respects and will fight to protect his right to practice medicine under the free enterprise system.
7. That he welcomes constant and close scrutiny by his colleagues.
8. That his profession recognizes other professions and wishes to participate with them in humanitarian programs.
9. That his personal conduct is in keeping with the highest moral standards of our society.
10. That he is a good neighbor, respected citizen and active participant in community affairs.

New ISMS TV Series For UHF Channel 26

"Medically Speaking"—an ISMS-produced half hour medical panel show—has been scheduled to begin as a weekly series this month on new UHF Channel 26 in Chicago.

Permanent panelists on the show will be Dr. W. W. Bauer of the American Medical Association and Dr. Abraham Galperin of Michael Reese Hospital. A different guest panelist will appear each week.

(continued on page 3, column 3)

WILL-GRUNDY Medical Society shows appreciation for its immediate past president Dr. James H. Lambert, right, at meeting in Joliet Jan. 8. Presenting plaque of appreciation is Dr. John McLaughlin. Mrs. Lambert shows complete delight at husband's award.





"SANTA"—alias ISMS Secretary-Treasurer Dr. Jacob E. Reisch—was a little late, but Drs. Max Klinghoffer, left, and George F. Lull didn't seem to mind at all. At annual Board Dinner January 11 Dr. Klinghoffer received plaque for his leadership in developing the Medical Self Help Training Program on television. A gold record was presented to Dr. Lull for having made more than 1,000 radio appearances in 1963. Although presented in spirit of fun, the plaques expressed sincere appreciation of the Board.

British Advise How to Avoid Socialized Medicine in U.S.

Plan your fight well and prepare for a long struggle or you will lose to socialized medicine.

That's the stern advice Dr. Julius M. Kowalski, ISMS Public Safety Committee Chairman, received on behalf of American medicine from members of the Royal Academy of Practitioners in London, England last month.

"We lost the fight because we had no effective alternate plan to offer our government," they told Dr. Kowalski. "American medicine must be ready to demonstrate beyond doubt the superiority of its independent system."

These opinions were contained in a detailed report to the AMA, which Dr. Kowalski represented at the British Medical Society Meeting in London, January 2-4, and the Latin American Medical Conference in Rome, December 18-21.

"British physicians assured me that if they took a vote today, they would not want to go back to the old system," Dr. Kowalski declared. "However, they admitted that their previous system of independent practice left much to be desired and had contributed significantly to its own downfall."

In Italy, where private insurance companies are executors of social security funds for medical care, physicians feel that they are underpaid and are dissatisfied with the system, Dr. Kowalski reported.

NEW TV SERIES *(from page 2)*

Format of the show is a light, non-clinical approach to common medical problems, with questions from the audience.

The show began February 10 at 4:30 p.m. and will temporarily continue to fill that time slot. Moderator is Richard Applegate, former NBC commentator and broadcaster.

County Societies to Strengthen Public, M.D. Link

Plans to develop lay speakers' bureaus in every county medical society and thereby strengthen the link of communications between the physician and public throughout Illinois were announced last month by the ISMS Public Relations Committee.

The county societies would make physician-speakers available as a public service to all lay groups interested in medical topics. In addition, they would actively promote this activity and solicit for speaker requests.

To help establish the bureaus, the ISMS Public Relations Committee and staff have prepared a complete plan of operation which was sent to the county medical societies during the first two weeks in February.

The ISMS House of Delegates —which has recommended this program—will receive a report of its progress at the 1964 Annual Meeting in May.

MSHT Films Available To County Societies

Demand for the highly successful ISMS Medical Self Help Training Program—presented last fall as an accredited television course in Chicago—has been so great that the complete television series is being made available on film to county medical societies, TV stations, schools, industries and service organizations throughout the state.

Limited quantities of the film course are available to county medical societies *without charge.* Special loan forms, along with a descriptive brochure, are currently being prepared for distribution to county medical society secretaries.

AUXILIARY NEWS

EDITOR
Mrs. Oliver Veneklasen
ASS'T EDITOR
Mrs. Theodore Proud

KISS FROM A DESERVING LADY



Santa guise of Secretary-Treasurer Dr. Jacob E. Reisch doesn't fool State President Mrs. M. E. Uznanski as she shows her appreciation for gift of roses. Board presented the roses plus inscribed gold medallion at Jan. 11 dinner for her "courage in accepting the highest Auxiliary office and executing its duties, energetically, effectively and without complaint." Dr. Reisch added on behalf of the Board, "we will always remember your tenure of office as one filled with inspiration and achievement."

Art Exhibit March 2-5

The Art Exhibit sponsored by the Woman's Auxiliary to CMS during their Clinical Conference March 2-5 is open to all doctors' wives.

Each entrant is limited to a total of two entries, which may be in any one of the four classifications listed:

Class I—Painting in oil based media

Class II—Painting in any water soluble media

Class III—Sculpture, any material

Class IV—Drawings and graphic art, including print techniques and collage

Address requests for blanks and information to: Mrs. Max Berg, *Exhibit Chairman*, 6931 Constance Avenue Chicago, Illinois.

Invitation

. . . for all members of the Woman's Auxiliary to the Illinois State Medical Society . . . to attend the Annual Benefit Luncheon sponsored by the Chicago Medical Auxiliary in connection with the Annual Clinical Conference. The luncheon will be held on Tuesday, March 3, in the Terrace Casino Room of the Morrison Hotel.

11:00-12:00—Social Hour with special Fashion Fantasia.

12:30—Luncheon and Fashion Show: COAST TO COAST CHIC A LA CHICAGO—with Saks Fifth Avenue fashions co-ordinated by Kay Dobson.

BRING GUESTS.

Prizes galore, including Week's Vacation for two at Eden Roc Hotel, Miami, and Mink Boa.

Donation per ticket: $6.00 . . . to Mrs. Harold Dubner, 910 Private Rd., Winnetka, Ill.

Proceeds of Benefit for: AMAERF, BENEVOLENCE and RECRUITMENT FUND.

1964 State Convention *Newsletter*

YOUR CONVENTION COMMITTEE

Seated from left: Mrs. Willard Scrivner; Mrs. Matthew Uznanski; Mrs. Richard Westland. Standing from left: Mrs. Silvio Del Chicca; Mrs. Mitchell Spellberg; Mrs. Alfred Pagano; Mrs. Murray Fuchsmann.



State Convention May 19, 20, 21

Sherman House, Chicago

Dear Auxiliary Member:

Please mark the above dates on your calendar and make every effort to come to the '64 Convention. Activities of many kinds are planned—some work, some play. By sharing these three worthwile days with your Auxiliary sisters, we promise you will gain new experiences, new proficiencies and new memories that will last a lifetime.

Sincerely,

the '64 Convention Committee

P. S. Look in the Pulse for detailed plans on convention activities in the months to come!

Record Lecture Available

Sex Education of Children by Parents

NARRATED BY
REV. FRANCIS L. FILAS, S.J.

For many people, their initial response to this 1½-hour recorded lecture is surprise, scepticism, embarrassment. But it rightly convinces many parents that sex education of children is not only proper and appropriate, but is nothing to be ashamed of or shy about.

More than 150,000 midwestern parents and engaged couples have heard it. The narrator, Rev. Francis L. Filas, S.J., Loyola University theologian and family counselor, has delivered the talk more than 500 times.

"Frankness" is one of its special qualities. Hardly an area of sex is left uncovered. It deals with physical differences, sex relations, physical modesty, language to use to explain sex, and what to explain at different age levels.

Father Filas counsels, "Use the technical name for the parts of the body as soon as possible so as to impress on the children that there is nothing vulgar or dirty about sex.

"Delicacy" and Respect Stressed

"Delicacy" is still another strong point of his talk. Father stresses that the way to delicacy in discussing sex, whether between a clergyman and parent, or parent and child, or a physician and a child, is "respect, respect, respect, and more respect."

But the most important quality of his talk is Father Filas' basic point of view toward sex education, which he sums up when he says:

" Sex education basically is understanding all that is meant by male and female. . . . in its full sense, sex education deals with the total character, personality and spirit of a person, as it is affected by his or her sex."

Some of Father Filas' opinions on introducing sex education to a child have surprised his listeners and will likely continue surprising

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those who expect a clergyman to take a strict, cover-up attitude toward sex matters. "Bathing the children together is one of the best ways to explain the sex organs" is one such opinion.

Another is "If your child is old enough to ask about sex, he is old enough for an answer." Also, "Sex education ideally should come from the parents. The school should not be expected to do this because the parents alone have the best opportunity, the responsibility, and the dignity and closeness to be able to give the children the sex education they should have."

The album, consisting of two 33⅓ LP records, carries the same title as Father Filas' talk. Because of its contents, the album will not be sold through record shops, but only by mail. Individual registration by number of every subscriber who orders the record will be further insurance that the record will serve its intended use. It is priced at $6.26 including handling and mailing costs.

M.D.'s in the News

New President for Will-Grundy County Medical Society

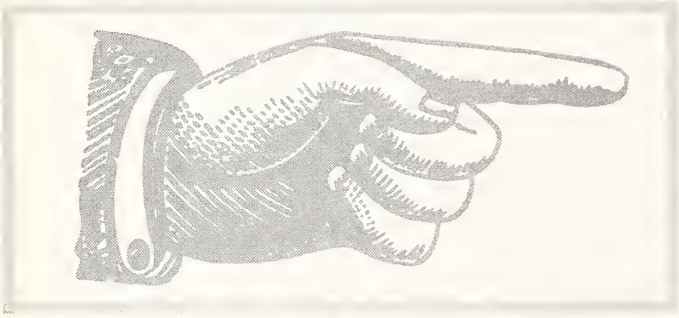
Doctor John J. McLaughlin has succeeded **Doctor James H. Lambert** as president of the Will-Grundy County Medical Society. He was installed at a dinner held in the Terrace Room of the Woodruff Hotel on January 8, 1964.

Other Officers Elected

Other elected officials were: Vice President, **Dr. Barry Seng** of Morris; Secretary-Treasurer, **Dr. Frank C. Bender** of Plainfield; Delegate to the Illinois State Medical Society, **Dr. Leonard F. Roblee** of Lockport; Secretary-Treasurer-elect, **Dr. John H. Kendall** of Joliet; and President-elect, **Dr. Robert J. Becker** of Joliet.



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County Society Administrator
Harold J. Homann Dies Jan. 10

Harold J. Homann, 60, executive administrator of the Winnebago County Medical Society since Sept. 1, 1962 and a former boy scout exeeutive, succumbed in a Rockford hospital Friday, Jan. 10 after suffering a heart attaek.

In his short tenure of service with the county medical society, Homann helped organize a suecessful Salk polio vaccine campaign in 1962 and conducted a highly active Community Health Week program last year. He also represented the soeiety at numerous state, regional and national meetings.

Following graduation from a national training school for scout executivcs, Homann joined the Alton Boy Scout council and from there carried on years of distinguished activity in scouting executiveship.

Deeply interested in juvenile delinquency, he has written four books on educational psychology while working for his Ph.D. degree in character education at the University of Chieago.

He was an active board member of the Big Brothers of America and a member of the Rockford Council of Social Agencies.

Surviving are his widow, Faye; a son, Harold W., of Columbus, Ohio; and his mother, Mrs. Wilhelmina Homann, Dousman, Wis.

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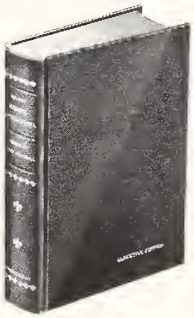
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PG Courses

Postgraduate Courses Being Offered by County Societies

Coles-Cumberland County Medical Society

Dr. John T. Reynolds, Clinical Professor of Surgery, University of Illinois College of Medicine, will speak on *Treatment of Benign Esophageal Stenosis,* on Wednesday, March 25, 1964, at the U.S. Grant Hotel, Mattoon, Illinois. Dinner at 7:30 P.M.

LaSalle County Medical Society

Dr. Lawrence Breslow, Clinical Associate Professor of Pediatrics, University of Illinois College of Medicine, will speak on *A Common Pediatric Problem—Recurrent Respiratory Infection,* on March 12, 1964, at the Ottawa Boat Club, Ottawa, Illinois. Dinner at 6:00 P.M.

Lee County Medical Society

Dr. Herbert F. Philipsbom, Assistant Professor of Pediatrics, Northwestern University School of Medicine, will discuss *The Management of Hemolytic Diseases of the Newborn,* on February 27, 1964, at the Nachusa House, Dixon, Illinois. Dinner at 6:00 P.M.

Livingston County Medical Society

Dr. Louise Tavs, Associate Professor of Clinical Dermatology, University of Illinois College of Medicine, will speak on *Common Eruptions of the Hands,* on Wednesday, March 18, 1964, at the Palomar Country Club, Pontiac, Illinois. Dinner at 6:30 P.M.

Whiteside County Medical Society

Dr. Armand Littman, Associate Professor of Medicine, University of Illinois College of Medicine, and Chief, Medical Service, Veterans Administration, Hines, Illinois, will discuss *Reeognition and Treatment of Aeute and Chronie Panereatitis,* on February 27, 1964, at Gordon's Restaurant, Sterling, Illinois. Dinner at 7:00 P.M.

(continued on page 194)

Meeting Memos

MARCH

Amerieaan Association of Anatomists, Denver, Mareh 31-April 3.
Amerieaan College of Sports Medieine, Hollywood Roosevelt Hotel, Hollywood, Calif., Mareh 19-21.
Amerieaan Orthopsyehiatrie Assoeiation, Conrad Hilton Hotel, Chieago, Mareh 18-21.
Medieal Students Aid Soeiety, Diplomat Hotel, Hallandate, Fla., Mareh 14-21.
National Assoeiation of Reereational Therapists, Lord Baltimore Hotel, Baltimore, Mareh 16-20.
National Conferenee on Rural Health (17th), Columbus Plaza Motor Hotel, Columbus, Ohio, Mareh 6-7.
North Amerieaan Clinieal Dermatologie Soeiety, Continental Hilton and Aeapulco Hilton Hotels, Mexieo City, Mareh 8-15.
Symposium on Fundamental Cancer Researeh, Houston, Mareh 2-4.
Symposium on Kidney Disease, Sheraton-Chieago Hotel, Chieago, Mareh 25.

APRIL

Amerieaan Aeademy of General Praetiee, Convention Hall, Atlantie City, N.J., April 11-16.
Amerieaan Assoeiation for Caneer Researeh, Edgewater Beaeh Hotel, Chieago, April 9-11.
Amerieaan Assoeiation for the Study of Neoplastie Diseases, Sherman House, Chieago, April 20-22.
Amerieaan Assoeiation of Immunologists, Chieago, April 12-18.
American Assoeiation of Railway Surgeons, Drake Hotel, Chieago, April 8-10.
Amerieaan Broneho-Esophagologieal Assoeiation. St. Franeis Hotel, San Franeiseo, April 7-8.
American College Health Assoeiation, Hilton Hotel, Denver, April 14-18.
Amerieaan Gastroenterologieal Assoeiation, Sheraton Hotel, Dallas, April 23-25.
Amerieaan Physiologieal Soeiety, Morrison Hotel, Chieago, April 12-17.
American Psyehosomatie Soeiety, Sheraton Palaee Hotel, San Franeiseo, April 4-5.
Amerieaan Soeiety of Abdominal Surgeons, Sherman Hotel, Chieago, April 19-22.
Amerieaan Soeiety of Internal Medieine, Atlantie City, N.J., April 3-5.
Industrial Medieal Assoeiation, Pittsburgh-Hilton Hotel, Pittsburgh, April 13-16.
Student Amerieaan Medieal Assoeiation, Sherman House, Chieago, April 29-May 3.

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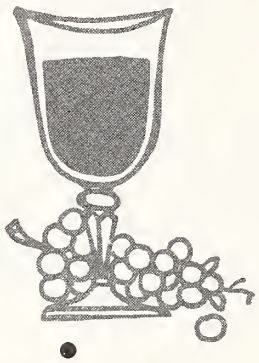
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And wine can be used in cooking to add sparkle, subtle flavor and appetite-appeal to soups, sauces, chicken, meat and other foods.

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(continued from page 192)

Postgraduate Course Offered by Chicago Committee on Trauma of the American College of Surgeons

The Eighth Postgraduate Course on Fractures and Other Trauma sponsored by the Chicago Committee on Trauma of the American College of Surgeons will be held April 22, 23, 24, 25, 1964, at the John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago.

Participating in the course will be well known teachers and surgeons from the five medical schools of Chicago and several distinguished visiting lecturers who will discuss many phases of trauma, fractures and dislocations in children and adults, hand injuries, nerve injuries, plastic surgery, tendon injuries, trauma to the head, chest, genito-urinary system, blood vessels, shock, respiratory obstruction in trauma, the prevention and treatment of wound infections, fracture healing, as well as symposia on the management of injuries of the knee and abdominal injuries.

Sir Reginald Watson-Jones of London, England, an eminent orthopaedic surgeon and outstanding lecturer, will be the honored visiting guest lecturer and will speak on Pitfalls in Radiographic Examination; Repair of Fractures—Safe Conservation or Dangerous Operation; Operative Treatment of Fractures; Ununited Fractures—How to Achieve Certain Success; Dislocations and Recurrent Dislocations of the Shoulder; How Do I Treat Fractures of the Femur; Unusual and Difficult Problems in the Treatment of Fractures and Dislocations; and Rehabilitation After Bone and Joint Injury.

Dr. Sam W. Banks is Chairman of the Chicago Committee on Trauma of the American College of Surgeons, Dr. J. D. Farrington is Secretary-Treasurer, and Dr. John J. Fahey is Chairman of the Committee on Postgraduate Courses on Fractures and Other Trauma of the Chicago Committee on Trauma of the American College of Surgeons.

Hospital announcements will be mailed to all hospitals on January 15, 1964. Individual physician notices, with the preliminary pro-

gram, will be mailed on February 1, 1964.

The registration fee will be $75.00. Each registrant will be a guest of the Chicago Regional Committee on Trauma for one luncheon and for the cocktail party on Thursday evening, April 23rd, at the Drake Hotel.

Dermatology Program For *ISMS* Convention Finalized

Sessions of the Dermatology Section will be held on Tuesday, May 19, 1964. The schedule is as follows:

9:00 A.M. to 9:30 A.M.: *Cutaneous Manifestations of the Anemias*, Dr. Samuel M. Bluefarb, Professor of Dermatology, Northwestern University Medical School, Chicago, Illinois.

9:30 A.M. to 10:00 A.M.: *Some Skin Aids in Diagnosis of Visceral Diseases—If You Look For Them*, Dr. Leon Goldman, Professor of Dermatology, University of Cincinnati Medical School, Cincinnati, Ohio.

10:00 A.M. to 10:30 A.M.: *Cutaneous Manifestations of Collagen Diseases*, Dr. Louis Rubin, Professor of Dermatology, University of Illinois College of Medicine, Chicago, Illinois.

10:30 A.M. to 11:00 A.M.: Intermission.

11:00 A.M. to 11:30 A.M.: *Cutaneous Manifestations of Vascular Diseases*, Dr. Frederick Szymanski, Professor of Dermatology, University of Illinois College of Medicine, Chicago, Illinois.

11:30 A.M. to 12:00 Noon: *Cutaneous Manifestations of Gastro-intestinal Diseases*, Dr. Allan Lorincz, Professor of Dermatology, University of Chicago Medical School.

12:00 Noon: Luncheon and business meeting.

Forms For Registering Clinical Labs

Forms for the registration of Clinical Laboratories, Blood Banks, and Blood Bank Depositories to comply with the "Illinois Laboratory Registration Act" of 1963, may be obtained by writing to the Legislative Division, Illinois State Medical Society, 360 North Michigan Avenue, Chicago, Illinois.

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ART EXHIBIT PLANNED FOR HOSPITAL X-RAY DEPARTMENT

A novel experiment in hospital-community public relations is being developed at Grant Hospital, Chicago, Illinois. If all goes according to plan, an art exhibit will be presented in the corridors of the hospital's department of radiology in March of this year.

Students from 27 elementary and high schools located in the region served by Grant Hospital will contribute original works of art to the exhibit. Ballot boxes will be placed in convenient sites so that all viewers—including patients waiting for radiological services—may vote for potential winners. Prizes will be donated and awarded by the department of radiology.

When the exact date of the exhibit has been determined, it will be announced in the *Journal.* Dr. Myron Melamed, originator of the project, extends a cordial invitation to all who would like to view the exhibit.

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NEW ASSISTANT EDITOR FOR JOURNAL



Robert J. Zavrel

Robert J. Zavrel was named assistant editor of the *Illinois Medical Journal* in January, 1964. He assumed his new duties immediately after the resignation of the previous assistant editor, Miss Joanne Twomey.

Mr. Zavrel is a graduate of St. Procopius College, Lisle, Illinois, and he has done graduate work at the Marquette University School of Medicine. Prior to his association with the *Journal,* Mr. Zavrel was science editor for Compton's Encyclopedia.

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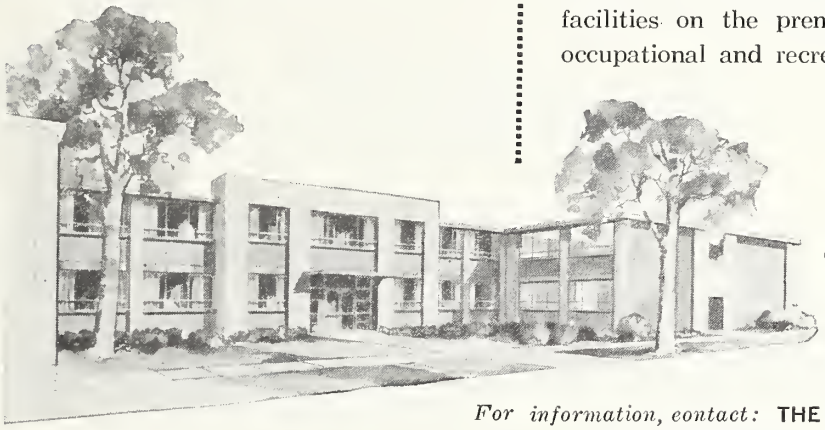
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Obituaries

C. E. Anderson*, St. Charles, died December 11, aged 76. He was a graduate of Rush Medical School in 1925 and a staff member of Delnor Hospital and Illinois State Training School for Boys.

Lloyd L. Arnold*, Chicago, died December 25, aged 75. A former member of the Chicago Board of Health, he graduated from Vanderbilt University School of Medicine, Tennessee, in 1919. Dr. Arnold was an emeritus member of ISMS.

A. Henry Arp*, Moline, died December 20, aged 70. He was a graduate of the University of Pennsylvania School of Medicine in 1917, specializing in general surgery.

Dominic J. Baima*, Coal City, died December 12, aged 52. In 1937 he was a graduate of Loyola University School of Medicine. He was a member of the Academy of General Practitioners and on the staff of Joliet and Morris hospitals.

Albert H. Baugher, Chicago, a graduate of Rush Medical School in 1909, died November 15, aged 80. A specialist in pathology, he served as Cook County coroner's physician until his retirement in 1962.

F. E. Bollaert*, East Moline, died January 8, aged 67. He was a graduate of Northwestern University School of Medicine in 1922. He was in active practice for 40 years until his retirement, one week before his death. He was a past president of the Moline Public Hospital staff and a member of many medical organizations.

Albert P. Dado*, Chicago, died January 2, aged 49. A graduate of Loyola University School of Medicine in 1937 and an Army veteran of World War II, he had been head of the radiology department at Hinsdale Sanitarium and Hospital for the last 17 years.

Leonard C. DeLozier*, Peoria, died October 24, aged 61. He was a graduate of Northwestern University School of Medicine in 1934 specializing in otolaryngology.

Harry A. Dimond*, Bartonville, died January 12, aged 80. He was a graduate of Chicago College of Medicine in 1913, a veteran of World War I, and staff psychiatrist for Peoria State Hospital for the last 17 years. He was a member of the Fifty Year Club of ISMS and also a member of the American Psychiatric Association.

Anthony M. Drummy*, Lincoln, died December 28, aged 77. A graduate of Northwestern University School of Medicine in 1913, he retired in 1959. He was an emeritus member and a member of the Fifty Year Club of ISMS.

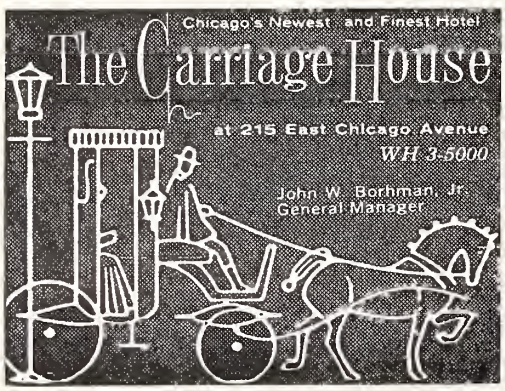
Marshall W. Field*, Chicago, died December 17, aged 68. In 1922 he graduated from Rush Medical College and specialized in obstetrics and gynecology. He was medical education director of Ravenswood Hospital.

William J. Hagstrom*, Chicago, was a graduate of Loyola University School of Medicine in 1928. He was a staff member of Little Company of Mary Hospital where he died December 17, aged 64.

Louis E. Halperin*, Chicago, died January 26, aged 73. He was a graduate of Jenner Medical College in 1915 and a specialist in internal medicine.

Theodore L. Hansen*, Minneapolis, formerly of Chicago, died January 18, aged 74. In 1916 he was a graduate of Northwestern University Medical School. He had been chief surgeon of the Rock Island Lines since 1936 until his retirement in 1955.

Harry H. Hart, Springfield, graduated from the University of Michigan Medical School in 1940. A member of the American Academy of General Practitioners and the American Society of Clinical Hypnosis, he died December 12, aged 51.



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MEDICAL DIRECTOR



Robert E. Johnson, Danville, died December 30, aged 81. He was a graduate of the University of Louisville Medical School in 1912 and was the oldest practicing physician in the Danville area.

Roland F. K. Jordan, Pekin, died December 16, aged 58. A graduate of Chicago Medical School in 1932, he was a veteran of the Army medical corps in World War II.

Parsegh B. Kanlian*, LaGrange, died December 11, aged 70. Originally from Turkey, he studied at the American Medical School in Beirut, Lebanon, and after coming to America in 1914 he completed his studies at Rush Medical College. A veteran of the Army medical corps in World War I, he became one of the first staff members of Community Memorial Hospital.

Louis E. Levin*, Pontiac, died December 11, aged 59. He graduated from the University of Illinois College of Medicine in 1937 and specialized in pulmonary diseases. A World War II veteran, he was the medical director of the Livingston County Tuberculosis Association.

Francis P. Mangan*, La Grange Park, died December 16, aged 51. A graduate of Loyola University Medical School in 1939, he specialized in radiology. A staff member of Central Community hospital, he belonged to the Radiological Society of North American and the Chicago Roentgen Society.

Horace P. Moulton*, Petersburg, died January 1, aged 90. In 1899 he graduated from Chicago Homeopathic Medical School. He was a member of the Fifty Year Club of ISMS.

William D. Nestos, Chicago, was a graduate of Chicago Medical School in 1937. He died December 13, aged 52.

Wilber E. Post*, Evanston, died December 22, aged 86. In 1903 he graduated from Rush Medical College and he later became dean of the same school. He had been on the medical staff of Presbyterian-St. Luke's since 1910. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Eberhardt H. Quandt*, Rockford, died December 20, aged 67. A graduate of the State University of Iowa College of Medicine in 1925, he was a veteran of both world wars. He was also a former president of the medical staff of St. Anthony Hospital where he had served as a staff member for 34 years.

Israel L. Sherry*, St. Petersburg, Florida, a retired Chicago physician, died January 10, aged 75. He was a graduate of Rush Medical College in 1912 and he specialized in pediatrics. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Otis O. Stanley*, Decatur, died January 10, aged 89. He was a graduate of Northwestern University School of Medicine in 1906. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Saul A. Sugar*, Chicago, was a graduate of the University of Illinois College of Medicine in 1926. A member of the psychiatric commission of Cook County family court, he died December 24, aged 61.

Edwin R. Talbot*, Joliet, died December 22, aged 71. He was a graduate of the University of Illinois College of Medicine in 1915.

Bradley P. Tillotson, Sidell, died December 11, aged 72. He was a graduate of Northwestern University School of Medicine in 1930.

Maya Unna*, Hinsdale, originally from Lund, Sweden, was a graduate of the University of Vienna College of Medicine in 1936, specializing in pediatrics. She was co-ordinator of the Michigan State Crippled Children's Commission and a staff member of La Grange Community Hospital and Hinsdale Sanitarium. She died December 27, aged 55.

Robert M. Watrous*, Highland Park, died December 14, aged 55. In 1936 he graduated from Northwestern University School of Medicine. A former president of the Lake County Medical Society, Dr. Watrous had been associated with Abbot Laboratories for 26 years.

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LEGISLATIVE LISTENING POST

March, 1964

ENFORCEMENT OF LICENSING ACTS

The Illinois Department of Registration and Education will check every doctor in the state to determine whether or not he is licensed.

A stepped-up program of enforcement of various licensing acts was announced by William S. White, Director of the Department of Registration and Education, at a meeting attended by ISMS representatives on February 11, 1964. Director White stated that anyone not licensed would be stopped; those who persist will be prosecuted. The drive will start by requesting each hospital and nursing home to forward to the Department names of staff doctors. If no reply is received, an investigator will follow up.

Any physician beyond the fifth year of training is subject to licensure. Out-of-state physicians may obtain temporary licenses when undergoing approved training.

Spot inspections to uncover unlicensed practitioners of all types in the healing arts will be intensified.

PRESIDENT ENDORSES KERR-MILLS

Following earlier news conference endorsement of medical care under social security, Johnson renewed the appeal in his February 10 health message. The theme was based upon the oft-disproved estimates that the program could be financed by workers contributing $1.00 per month during the working year.

Somewhat surprisingly, he commented on Kerr-Mills by stating, "Therefore, I urge all states to adopt adequate programs of medical assistance under Kerr-Mills legislation. It will be needed later as a supplement to hospital insurance."

Apparently, the President agrees that Fedicare will not answer the problems of the needy aged.

LEGISLATION IMPLEMENTING HEALTH MESSAGE

Three sets of bills sponsored by Senator Hill (D-Ala.) and Representative Harris (D-Ark.) have been introduced to implement the President's February 10 Health Message. They are: S-2531 (H.R. 10004) -- extends Hill-Burton Law for five years -- provides grants for construction or modernization of urban hospitals, and grants to a new single category of long-term care facilities formerly separated as chronic disease hospitals and nursing homes; S-2529 (H.R. 10042) -- provides for construction grants to build schools of nursing and federal student nurses loans; S-2530 (H.R. 10043) -- expands public health traineeship program and project grant program for graduate training in public health.

REPRESENTATIVE FINDLEY'S MEDICARE PROGRAM

Representative Findley promises prompt medical attention for anyone in the 20th Congressional District who is not getting adequate medical care. Representative Findley will check each case called to his attention and provide for medical care under available medical service programs. Representative Findley states that, "unfortunately, many people are not aware of what is available and perhaps occasionally go without needed medical care for lack of information. My referral service is intended to meet this problem."

24th AMENDMENT

Ratification of the 24th Amendment has been completed. The Amendment is now part of the Constitution. It abolishes the state poll tax as a factor in federal elections.

PRESIDENTIAL HEALTH COMMISSION

President Johnson has declared that he will create a commission on heart disease, cancer and strokes.

IMJ

Illinois Medical Journal

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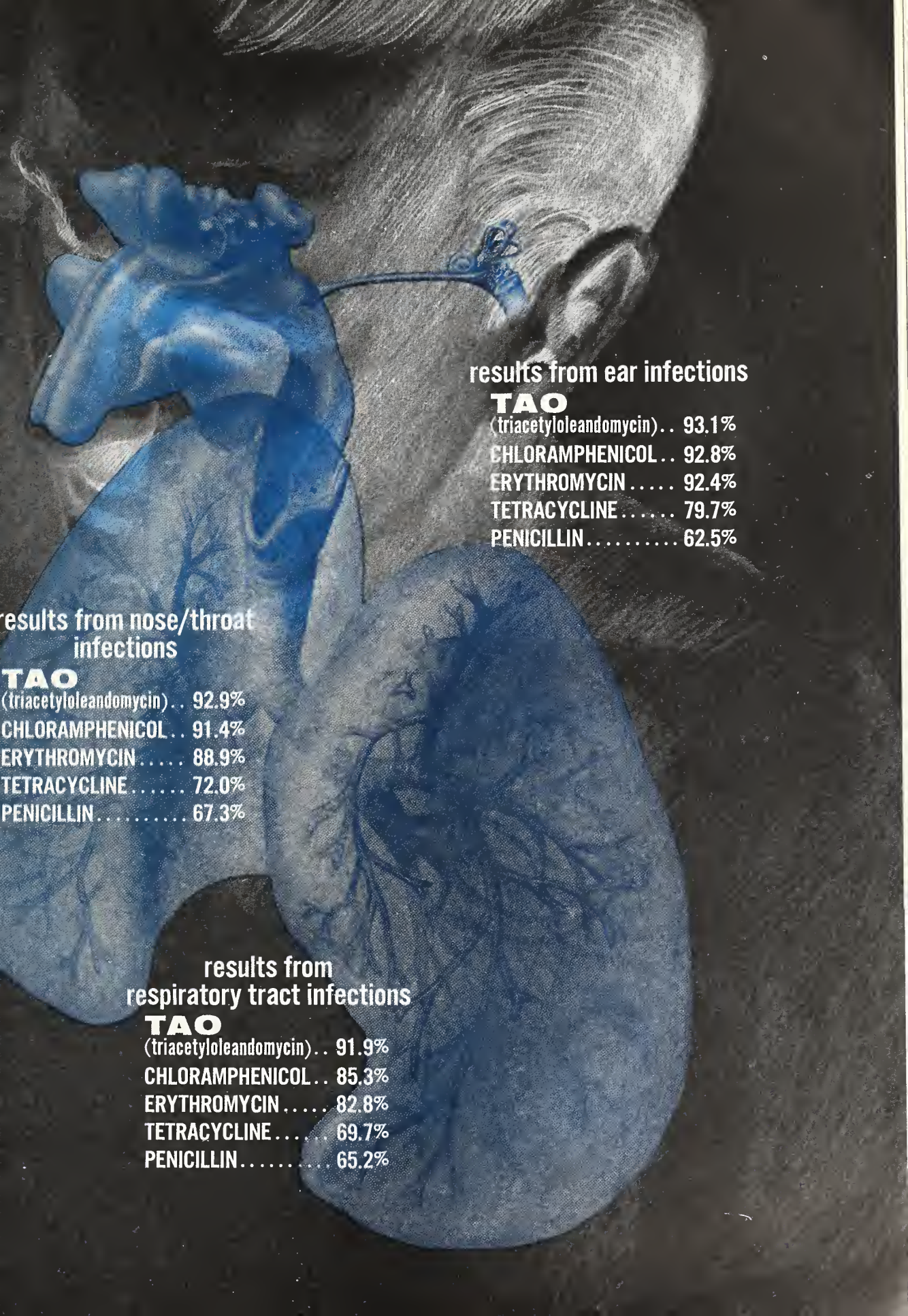
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ERYTHROMYCIN..... 82.8%
TETRACYCLINE..... 69.7%
PENICILLIN..... 65.2%



AS I SEE IT FROM '360'

By Robert L. Richards
Executive Administrator

The Young Doctor and His County Medical Society

Many a physician believes that the county medical society to which he belongs—or should belong—is controlled by some clique. Isadore Zadek, M.D., past-president of the Westchester (New York) County Medical Society takes vehement exception to this premise. He points out that the so-called clique within a county medical society is invariably composed of those men and women who are willing to do the work that is necessary to keep the society functioning.

Dr. Zadek is firmly convinced that ideas such as the "clique myth" are largely responsible for the fact that many young physicians are apathetic about participating in the activities of a county medical society. And this at a time when every county society desperately needs vigorous workers—particularly young ones.

Why, exactly, should a young physician interest himself in the workings of his county medical society?

"Most M.D.s," says Dr. Zadek, "are somewhat insecure when they start out in the practice of medicine. During his medical school years and hospital training someone else assumed the ultimate responsibility for the welfare of the patient he saw. Now he is on his own to a greater degree."

Dr. Zadek goes on to explain that the young doctor now realizes that he should become a member of the AMA. But, before he is accepted by the AMA he must be a member in good standing of his county medical society.

The young doctor should, of course, attend his county society meetings. This gives him an opportunity to continue his education and at the same time to meet his fellow physicians—young and old—and to become an integral part of the organization. Here he can learn, at first hand, the problems that face the practitioner of medicine today. It is here, at the county society level, that he learns the sometimes bitter truth about the unqualified lay administrators and bureaucrats who have legislated themselves into positions of control and regulation of his professional activities.

"Above all," continues Dr. Zadek, "the young doctor will come in contact with men who have survived the trials and tribulations and are ready to give him a helping hand."

In a few weeks the Illinois State Medical Society will provide each of its members with a kit of materials which will explain the varied activities of the AMA, the ISMS, and his own County Society. It is hoped that this kit will assist the physician in concluding that we are not merely organizations which spend his dues. If any member of ISMS would like to have such a kit, we will be pleased to furnish him with one upon request.



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Editorial

The Mark II Auto Tutor was used recently as a teaching machine for diabetic patients.[1] It looks like a small TV set but is in reality a special 35 mm. film projector with a near view projection screen. The script was prepared by specialists in the field. The project was conducted by the Medical Foundation, Inc., under contract to the Diabetes and Arthritis Program, Division of Chronic Disease, U.S. Public Health Service.

A random selection of 184 diabetic patients were used to test the efficiency of the machine. The majority learned and enjoyed it. It was of no value to the illiterate, language handicapped and those with poor vision. The method is of particular value to newly diagnosed diabetics.

The patient sits before the machine and reads a short discussion on a phase of diabetes. A question is asked at the bottom of the strip with three possible answers. If he pushes the button opposite the correct answer, the machine automatically advances to the next lesson. If the individual makes an incorrect choice, he is told why the answer is incorrect and is asked to push the button 'R' that brings back the original information.

Automated teaching is big business. There are 137 manufacturers and publishers in the field. Many medical schools, including the University of Illlinois College of Medicine, are exploring the potential of this method of teaching and are comparing the results of a programmed instructional material with the standard lecture approach.

Teaching machines may prove to be a boon to the busy practitioner who does not have the time or staff to acquaint his patients with the details of their ailment. It has the advantage of being available at a time convenient to the patient. This type of automation makes sense. Those with chronic diseases, such as diabetes, are most likely to benefit.

T. R. VAN DELLEN

1. Nickerson, Hiram H.: A Teaching Machine for Diabetic Patients, J. Maine Medical Association 54:231 (Nov.) 1963.



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Perforation of Duodenal Ulcer in the Newborn

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Perforations of the alimentary tract in the newborn do not occur very frequently. When they do, however, they are usually found at autopsy.

There are several reasons why some portion of a newborn's alimentary tract may become perforated. Distention which is produced by obstruction, for example, can cause perforation of the stomach, the ileum, or the colon. Ulceration of the duodenum—in which a "punched-out zone" in the duodenal wall permits egress of gastro-duodenal contents into the peritoneal cavity—is another cause of alimentary tract perforation in the newborn.

The purpose of this report is to present two cases of newborn infants who survived perforations of duodenal ulcers. The individual described in the first case is now 13 years old. The child who represents the second case is two months old.

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Report of Case 1

A 24-year-old para 0, gravida 1, was admitted to an obstetrical service on March 15, 1951. At 1:30 P.M. on that day she delivered a six-pound 14.5-ounce normal appearing female infant.

On the next day the infant passed a small meconium stool. She would not take the formula, and she vomited several times. Her weight declined by three ounces. Vomiting continued through the day.

On March 18 the infant's temperature was 99° F. The child was vomiting a bile-stained material. She was pallid, her abdomen was distended, and bowel sounds were absent. She was given a transfusion of 5 cc whole blood and 300 cc of fluids. These were administered subcutaneously. A roentgenogram showed a very large amount of free air in the abdomen. This free air shifted whenever the patient's position was changed (Case 1, Figures 1 and 2, on next page).

Laboratory studies showed the hemoglobin level to be 108.9 per cent (16.6 gm, Haden-Hauser). Red blood cells were 4.9 million. WBCs were 8,450 per cubic millimeter, with 150 segmented cells, 50 lymphocytes, and four-to-five nucleated red blood cells per 100 white blood cells.

Surgery

On March 19, decompression of the stomach was



Case 1 Figure 1



Case 1 Figure 2

Peritoneal cavity distended with large amount of free air: The air surrounds the abdominal viscera and extends into both subphrenic regions.

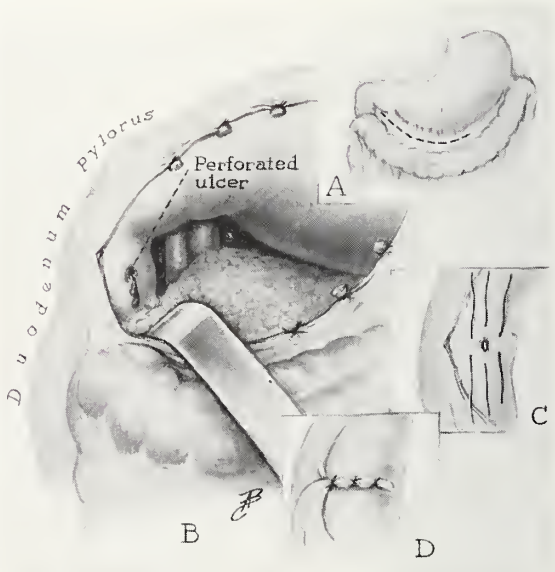
achieved by means of suction through a Levin tube. Laparotomy was performed through a right rectus incision (paramedian). Free air and clear fluid were encountered in the greater peritoneal cavity. A bile-stained fluid was found in the right subhepatic space, and a thick exudate flowed from the Foramen of Winslow.

The lesser peritoneal cavity was explored through an opening in the gastrocolic ligament. A two-millimeter perforation was found on the posterior aspect of the first portion of the duodenum (within five millimeters of the duodenopancreatic angle). Bile-stained duodenal contents flowed through this aperture. Three 0000 silk sutures were used to close the defect (Case 1, Figure 3).

Postoperative Course

During the postoperative period the patient was given 50 cc of whole blood, 250 cc of five per cent dextrose in saline with hyaluronidase (Alidase), and 200,000 units of penicillin. Gastric decompression was continued.

On the day following surgery, the patient's temperature was 101° F. Distention was decreased. No bowel sounds were heard. Dyspnea and slight cyanosis were overcome with oxygen (three liters per minute) administered through a mask. There was a small meconium stool, and 200 cc of urine were excreted in 25 hours.



Case 1 Figure 3



Case 2 Figure 1



Case 2 Figure 2

Supine and left lateral descubitus films of the abdomen: A large amount of free air and fluid loculated over the liver, Gaseous distention of stomach and small bowels.

During the next two days the temperature rose to a maximum 104.8° F. Intravenous feedings consisted of five per cent dextrose in Ringer's solution. Whole blood transfusions were given. On March 22, when the temperature was 104.8° F., oxygen was administered by mask. Penicillin was given and gastric suction was discontinued.

On March 23 the temperature was 103.6° F. Ringer's solution with dextrose was given orally in amounts of two ounces every three hours. The decompression tube was removed because of dyspnea, regurgitation, and transient cyanosis. By March 24 the temperature was 100.8° F. Oral feedings were continued, and were retained by the infant. There were frequent golden-yellow stools. The incision was draining serum.

After March 27 the temperature never rose above 99° F., nor did it fall below 98° F. during the remainder of the infant's stay in the hospital. Water and formula were taken well every three hours. On March 28 the child's weight was six pounds nine ounces. Movements of the gastrointestinal tract were satisfactory.

The skin and subcutaneous tissues did not heal. However, the fascia remained closed. On April 5 the condition of the wound remained unchanged. The baby weighed six pounds 11 ounces. On April 13 the patient was discharged in good condition. Eventually, the wound healed by secondary union. The fascial wound did not open. In March, 1953, the child was well developed and free of any gastrointestinal disturbance. No further evidence of ulcer appeared.

Report of Case 2

A 26-year-old para 5, gravida 5, was admitted to an obstetrical service on January 14, 1964. On that day she was delivered spontaneously of a full-term normal female infant (APGAR score 10). The infant's weight at birth was six pounds 15 ounces.

At eight hours the child appeared normal and healthy. During the next 24 hours she was fed glucose water followed by evaporated milk formula. Urination and two meconium stools took place on the first day. After 48 hours the child became irritable. It cried most of the time. At 51 hours she appeared dusky. Temperature was 99° F. Respirations were 38 per minute, heart beat was 130 per minute. Her color became greyish and sallow. The skin was dry. The abdomen was tense, minimally distended, and tympanitic. Bowel sounds were diminished.

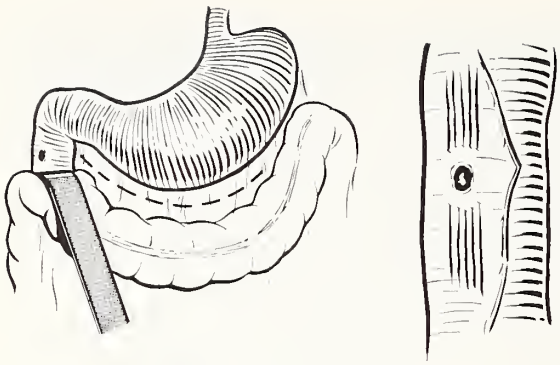
Two meconium evacuations had taken place during the previous four hours. There was no vomiting. Neurological responses were normal. There was no grunting, and the cry and other responses were active. She was placed in an incubator with oxygen and high humidity.

Hemoglobin was 212 gm. Hct. was 65. WBCs were 5,700, with 33 polys, 63 lymphocytes, and 4 monocytes. At 56 hours an upright roentgenogram of the chest and abdomen disclosed the presense of free air in the perintoneal sac (Case 2, Figures 1 and 2).

Surgery

Under drop ether anesthesia a high right rectus paramedian incision was made. Exploration of the area showed the peritoneum to be discolored with a bile-stained fibrinous exudate, and a bile-stained fluid which contained some milk. A three-millimeter perforation, which was seen in the anterior wall of the upper end of the second portion of the duodenum, was closed by five interrupted sutures of five 0 silk (Case 2, Figure 3).

The peritoneal sac was irrigated with warm saline solution and closure of the abdominal wall was made with two layers of interrupted silk sutures. During the



Case 2 Figure 3

period of anesthesia 60 cc of 0.2¼ per cent saline solution in 5 per cent dextrose was administered.

A saphenous vein "cut down" was canulated for I-V fluid administration. The infant was placed in an incubator with oxygen and high humidity; a nasogastric tube was intermittently opened and the bile stained contents were aspirated. Quantities of 35 to 99 cc of clear yellowish gastric secretions were recovered daily for the first three days. At the end of this period the gastric suction was discontinued. Oxygen was discontinued four hours after surgery.

Intravenous fluids consisted of one-quarter strength saline in 5 per cent dextrose water at a rate of 85 ml per Kgm per 24 hours. Fifty cc of whole blood were given six hours after surgery. Potassium chloride 6 m.eq. and 4 m.eq. were added (mixed) to the above mentioned fluids for the third and fourth post operative days, respectively. Penicillin 100,000 u. intramuscularly was given daily for 10 days, and Kanmycin 15 mgs per Kg per day I-M in two divided doses for five days.

Post Operative Course

The patient's post operative course was uncomplicated. From the immediate post surgery period per responses were active, her cry vigorous and her color good. She urinated adequately and passed normal appearing stools. Temperature, heart rate, and respirations remained normal throughout. The CBC on the second post operative day showed Hb. 18.7 gm; Hct. 56; WBC 6,500; stabs 14, segs 30; lymphs 52; monos 4. Urinalysis was negative.

Water feedings were started on the third post operative day and evaporated milk formula on the fourth with gradual increments. No vomiting or regurgitation occurred.

On the fifth post operative day Hg. was 17.8; Hct. 57; and WBC 21,000 (stabs 10, segs 58, lymphs 28, mono 3, eos 1). Five days later Hg. was 16.5; Hct. 48; and WBC 17,500 (43 segs, 4 stabs, lymph 51 and mono 2). Urine was negative on these dates. I-V fluids were discontinued on the fifth post operative day. The infant started to gain weight on the sixth post operative day. She was discharged in good condition ten days after surgery when the superficial sutures (skin) were removed. Two band-aids were used to support the wound.

Discussion

Although perforation of the alimentary tract in the newborn is comparatively rare, a number of such cases have been reported in recent years. Many of the infants described in these reports have survived only because prompt diagnosis of the perforation was made, and immediate surgical intervention closed the leak or removed the focus which caused the perforation.

Reams,[12] in 1963, reviewed the English literature dealing with stomach perforations in the newborn. He noted survivals in 20 of 100 cases reported.

Gastric perforations, according to the reports studied by Reams, may result from a variety of causes. The most common factors which can lead to gastric perforation in the newborn include: (1) perforation of a gastric ulcer, (2) rupture of a defective gastric wall, (3) distal obstruction of a distended stomach, and (4) trauma from external force or from perforation by a gastric tube inserted for feeding or for suction.

Perforations of the small bowel and colon are also due to a variety of causes. These perforations may be associated with intestinal obstruction, trauma, constipation, and defects in the intestinal wall. Survivals among this group have been relatively few.

In a previous publication,[7] a review of perforated ulcer cases in the newborn up to 1953 disclosed only a small number of individuals who survived surgery for the condition. Since 1953, however, ten such cases have been reported. Additional instances of recovery undoubtedly exist. To date, however, these have not been reported.

The subject of peptic ulcer has received widespread publicity in the lay press in recent years. The relationships between peptic ulcer and stress, the corticosteroids, the endocrine glands, the vagus nerves, and gastric acidity have been described and emphasized. Significantly, each of these factors plays a role in the etiology of peptic ulcer in the newborn.

Gastric Acidity in the Newborn

Ames[1] noted that nearly all full-term babies secrete gastric acid within three to six hours after birth. Most investigators believe that free hydrochloric acid is always present in the gastric juice of the unfed infant at birth.

The relationship between hypersecretion of acid gastric juice and duodenal ulcer is well known. Pepsin activity is considered essential to ulcer production. Pepsin is derived—in the presence of an acid medium—from pepsinogen, an exocrine secretion from the chief cells of the gastric mucosa. Pepsinogen, which is secreted as an endocrine into the blood stream, is stable in alkaline solution and it may be detected in both the blood and the urine.

Elevated pepsinogen levels have been noted in patients with duodenal ulcer. Grayzel[6] and his co-workers recently reviewed the subject of plasma pepsinogen levels in the newborn. These reports showed that the chief cells—which produce pepsinogen—develop very slowly in the human embryo. Some chief cell development takes place from the eighth to the ninth lunar month. Only in the tenth month, however, is there a significant increase in granules and peptic activity. At birth the chief cells of the fetal gastric mucosa have approximately one third of the adult complement of granules.

Demonstration by histochemical methods shows that the number of pepsinogen granules is much smaller in prematures than it is in full-term infants. This may account for low pepsinogen values in the urine of some prematurely born infants. The blood plasma pepsinogen levels are the same for older children as they are for adults. In the newborn, however, these levels tend to be higher.

Hypothalamic-Pituitary-Adrenal-Cortical Activity

The cellular integrity of peptic cells depends on normally functioning pituitary and adrenal glands. Excluding conditions which cause either destruction or atrophy of the gastric mucosa, stimulation of peptic cells comes from stress and from hypothalamic-pituitary-adrenal-cortical activity. It has been shown that hyperpituitarism, hyperadrenocorticism, and stimulation with corticotropin or with gluco-corticoids increases endocrine pepsinogen production and excretion. Urinary pepsinogen values parallel those of simultaneously determined 17-hydroxy-corticosteroids.

Pregnancy and delivery represent a form of stress which may stimulate the adrenal cortex. There is sufficient experimental evidence to show that corticotropin and corticoids pass from the mother through the placenta into the fetus. In the newborn infant this may cause an elevated blood level of corticoids.

The newborn is also subjected to stress. Thus the infant's adrenals may produce corticoids in reaction to such stress. Corticoids in the newborn are of exogenous and endogenous origin. Thus they may stimulate increased production of pepsinogen. Such increased pepsinogen production may continue for several days after the corticoid stimulus has stopped. This provides a possible explanation for the significantly high level of pepsinogen which is found even at the end of the first week of the neonatal period.

A 1932 report by Cushing[4] described cases in which acute perforations of the esophagus, stomach, and duodenum appeared from one to four days after operations on the brain for removal of tumors had been performed. All of these perforations were fatal. Cushing presented evidence which indicated that a parasympathetic center exists in the hypothalamus. This center sends fibers to the medullary vagus center. Cushing believed that injury to this diencephalovagal mechanism could cause erosions, perforations or ulcers in the esophagus, stomach, or duodenum.

Masten and Bunte[8] reported a series of eight fatal cases in which similar alimentary tract lesions caused gastric hemorrhage and escape of esophageal or gastric contents into the pleural or peritoneal cavity. These patients exhibited a variety of cerebral diseases which primarily or secondarily affected the dienchephalon. Cushing suggested that frequent occurrence of chronic gastric or duodenal ulcers in high-strung, vagotonic individuals could well be due to some disturbance in this suprasegmental part of the parasympathetic system. Experimental hypothalamic lesions induced in animals have produced changes in the stomach wall. These changes ranged from simple hyperemia to complete erosions through all coats of the stomach. A more detailed account of such experiments

may be found in Brock and Krieger.[2]

Comment

The survival of newborns with perforations of the duodenum depends on prompt recognition of the condition as soon as possible after it occurs. This is a significant responsibility of the nurse, of the house staff member assigned to the nursery, and of the attending physician.

Abdominal spasm and distention with muscle spasm and reduced intestinal sounds indicate the presence of peritonitis. Roentgenologic studies in the vertical and lateral positions (left lateral decubitis or vertical) are an aid to the recognition of perforation of the gastrointestinal canal.

The value of prompt recognition and surgical repair is emphasized. The use of antibiotics, whole blood and other intravenous fluids plays a role in the survival of the patient.

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Radium Therapy in Cancer of the Eyelid

J. Ernest Breed, M.D.*

Ever since artificially produced radioactive isotopes were made commercially available, it has been predicted by some that the use of radium would become passé. This rumor has persisted, even though none of the isotopes have equalled the efficiency of radium in advocated areas. The rapid increase in the use of radium during the past few years suggests a renewed confidence in this element. In treatment of cancer of the eyelid the versatility and efficiency of radium are well demonstrated.

Most malignant epithelial tumors of the skin occur on exposed surfaces, with the predominance occurring on the face. The parts of the face that lie at a greater angle to the rays of the sun such as the bridge of the nose, the skin over the malar bone, the forehead, the tops of the ears and the lower lip develop the most tumors.

The skin of the eyelids is a frequent site of malignant change. In our series of about 1,500 patients with cancer of the exposed surfaces of the head, 209 cases involved the eyelids.

The Lesion

The lesion usually begins as a small papule or as a flat, scaling surface a few millimeters across. Ordinarily its presence is known from its incipience, but being symptomless it is thought by the patient to be of little significance. As it gradually enlarges the patient becomes concerned and the assistance of a physician is sought.

If treatment is delayed the growth may invade adjacent or deeper structures and what was once a simple problem becomes a complicated one. A lesion growing on the skin surface of a lid, away from either canthus, does not present as difficult a problem as one involving either canthus or the mucous membrane. When the canthus is involved the growth may involve both lids and at the inner canthus may invade the caruncle and even grow down the lacrimal duct. A growth arising in the conjunctiva may involve the sclera.

A neoplasm of the upper lid may grow back into the orbit between the globe and the roof. When this occurs the prognosis is poor. Not only must the eye be sacrificed, but to remove or destroy all tumor cells lying against the roof is most difficult.

At times a neglected cancer will grow completely through the lid, involving both skin and mucous membrane surfaces. This complicates radiation therapy inasmuch as reaction in the tumor bed is essential in less radiosensitive tumors, and in this instance the tumor bed is limited to the thickness of the lid around the edge of the tumor.

Biopsy

As a general rule all tumors suspected of being malignant should be biopsied. This procedure, however, is not without danger. One of the most distressed patients I have ever seen was an elderly woman who developed a small squamous cell carcinoma of the left lower eyelid which was removed by excisional biopsy. When the pathologist's report was returned, she was referred by her physician to a large institution where postoperative radiation was administered. A few months later the patient developed metastasis in a lymph node located in the subcutaneous tissue over the left mandible, and in the left cervical nodes. A block dissection was done, cleaning out the left neck and the tissues over the mandible. Within a few months she developed left preauricular metastasis, involvement of the deep posterior cervical nodes and of the left submaxillary node. She refused further surgery and came to see me.

The fixed left preauricular node measured

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two centimeters in diameter. The fixed mass in the left posterior neck measured about four centimeters in diameter, and the left submaxillary node about three centimeters. With surface radium therapy it was possible to shrink the nodes and hold growth in abeyance for a time. The patient expired two years later with a large ulceration measuring about 25 by 10 centimeters in size and circumscribed by carcinoma extending from her xiphoid process to her mandible.

Before taking a biopsy of a lesion strongly suspected of being malignant, it is my policy to deliver a moderate dose of irradiation in divided portions to the surface of the growth, and then to take a small piece from the superficial and central part of the mass. The tumor bed is not disturbed.

Diagnosis

Occasionally a fleshy mole will be confused with cancer, but the long history and the relative softness of the mole should resolve the diagnosis. Chalazion cysts may be confused with cancer of the eyelid. The smooth skin or mucous membrane covering the cyst, coupled with evidence of associated inflammation, are significant findings. Blepharitis, epithelial horns, warts and keratoses are other lesions that must be considered. Blepharitis has all the evidences of inflammation, epithelial horns protrude as small 'horns' from a relatively soft base, warts have all the typical findings of warts in other locations, and keratotic lesions are usually flat and relatively soft. Any gradually enlarging, firm, new growth of the skin or mucous membrane surface of an eyelid should be considered malignant unless proved otherwise.

About 75 per cent of the malignant epithelial growths in the upper half of the face are basal cell, and 25 per cent squamous cell. A few will have both basal cell and squamous characteristics. These are designated as baso-squamous cell carcinomas. Occasionally an adenocarcinoma will be found.

The basal cell cancers in the upper half of the face often have a translucent appearance and frequently are incised under the mistaken idea that the new growth is a cyst. Frequently small telangiectatic blood vessels will be noted coursing across the surface of the growth. The mass is hard to the touch, and usually has a typical rolled border. Frequently the center of the growth is ulcerated. At times the ulcer will heal with a thin scar, while the periphery of the mass will continue to extend.

Cancers arising in the skin surfaces of the eyelids are more likely to be basal cell, while those arising in the conjunctiva are usually squamous cell. Basal cell cancer usually grows slowly. It seldom if ever metastasizes, but its continuous invasion of adjacent structures may in time cause massive destruction. Squamous cell cancer has the same general characteristics wherever situated. Those located on the skin as a rule grow more slowly than those located on mucous membranes.

It must be remembered that all malignant tumors differ one from the other. While general characteristics may be stated for tumors arising from the same type of cell, the behavior of any one tumor cannot be foretold. Some grow rapidly, some slowly; some metastasize, some never do; and some will ulcerate early, while others never ulcerate. The one thing they do have in common is that sooner or later practically all will destroy the host.

Clinical Material

This paper is based upon the study of 209 cases of cancer of the eyelid treated between the years 1934 and 1961. One hundred and two patients were men and 107 were women. The average age was 61.7 years, the youngest patient was 32, and the eldest, 84.

The lids of the left eye were involved in 106 patients, the right in 100, and both in three patients. In two patients lymph nodes were involved with metastasis on admittance. The largest growth measured 6 centimeters in diameter, the smallest, 0.4 centimeters and the average was 1.5 centimeters in diameter. Ulceration was present in 49, or about one-fourth of the lesions.

The duration of the growth, to the patient's knowledge, varied from one month to four years and nine months, with an average duration of 18 months. Only five patients suffered pain. Metastatic involvement of the lymph nodes were present in nine patients at some time in the course of the disease.

The lower lid was the seat of the disease in 114 patients, the upper lid in 48, the inner canthus in 89 patients and the outer canthus in 29. The primary growth was in the mucous membrane in 14 patients and more than one of these areas were involved in 67 patients. The lower lid was involved two and one-half times as often as the upper lid, and the inner canthus three times as often as the outer canthus.

Forty-nine patients, or nearly one-fourth of the total, had had previous treatment elsewhere. Four had been treated with radium, eight with x-ray, 27 had had surgical removal, and one, chemotherapy. Six patients had other types of treatments. Biopsies were performed on 42 patients after admittance to our office. Sixty-seven per cent of these were basal cell; 26.1 per cent, squamous cell; 4.6, baso-squamous cell, and 2.3, melanoma.

Ten patients had lesions involving adjacent areas, including the nose, the antrum, the globe, extensions into the orbit around the globe, and the deeper structures of the cheek. Seventeen patients had keratotic lesions of the face. Of interest is the fact that 57 patients had or subsequently developed primary malignant lesions elsewhere.

After the first course of radium therapy, 45 patients suffered from persistent tumor, lymph node involvement, or recurrence of the primary growth. Of these, 40 were retreated with radium, three referred for surgical removal, one received chemotherapy, and one was retreated with x-ray. Some of these patients suffered with advanced disease and were given palliative treatment only.

Treatment

Because of the proximity of other significant structures, the treatment of eyelid cancer requires special consideration.

In England the tendency is to treat the lesions with irradiation. Beta rays from radium are preferred for smaller lesions and gamma rays from radium (or x-rays) for larger and deeper infiltrating growths. In the United States the lack of familiarity with radium techniques leads to a tendency to treat these lesions with x-rays or to subject them to surgical removal. Except in very small lesions surgery is difficult, requiring elaborate, and sometimes multiple, plastic operations to repair the defect occasioned by the removal of even a moderate-sized malignant tumor. If the growth involves the caruncle or the sclera the problems of the surgical approach are compounded.

In this series of 209 patients, 167 were treated with beta rays from radium, 30 with gamma rays from radium, and 12 with a combination of beta and gamma rays from radium.

In many respects beta rays from radium are ideal in treating lesions about the eyes. Consisting of negative ions thrown out of the exploding nucleus of a radium atom, beta rays are very effective in ionizing the atoms of tissue cells, and at the same time they are completely absorbed in about one centimeter of tissue. This makes it possible to deliver a carcinomacidal dose to a lid cancer without appreciable danger to the lens of the eye. From one to three per cent of the energy eliminated by the radium applicator is in the form of gamma rays, which of course would reach the lens. The dose delivered by gamma rays, however, in the course of beta ray therapy, is too small to be of significance.

Gamma rays should be used for those cancers of greater thickness than six to seven millimeters. The globe is protected by a gold cup five millimeters in thickness, molded to fit over the organ. Gold has twice the screening power of lead and this screen will absorb about 50 per cent of the gamma rays. The inverse square law also assists in lessening the dose delivered to the lens. In my thirty years experience in the treatment of many hundreds of cancers about the eye, clinical evidence of cataract or other injury has never been observed, except in the treatment of massive tumors in which the eye was already condemned by the growth.

Radium Technique

Beta Rays

If possible the lid containing the epithelioma is pulled away from the globe with a piece of adhesive tape. A quarter strength beta ray plaque of suitable size and shape is screened with one tenth millimeter of lead to absorb the weaker rays. The applicator with its screen is wrapped in sheet rubber or cellophane and then is applied directly onto the surface of the

growth. The edges of the applicator should extend about five millimeters beyond the palpable edge of the tumor. A total of seven to eight hours treatment time, divided into six to nine treatment periods, is administered in two or three weeks. A typical radium reaction develops, which reaches its peak from seven to ten days after the last treatment. During this time the tumor shrinks and a crust is formed. From three to four weeks after completion of the course of therapy the crust comes away, leaving the skin surface smooth and soft. There will be no scar unless the tumor has ulcerated and already destroyed the normal skin.

Gamma Rays

As with beta ray treatment, the lid containing the tumor is pulled away from the globe with tape, if this is at all possible. The gold screen is then applied over the globe and strapped in place. A small block of wood or rubber of a thickness roughly equal to the thickness of the tumor is strapped over the lesion. A radium applicator containing 50 to 200 milligrams of radium screened to permit the passage of gamma rays only is strapped onto the block. The amount of radium in the applicator varies with the source skin distance. Twelve to 15 treatments of 15 to 20 minutes are usually given over a period of two or three weeks. The radium reaction reaches its peak in about two weeks after the last treatment, and gradually subsides over the next three to four weeks. During this time the tumor disintegrates and healing occurs.

Results

It is noted in the table of results given that of 117 determinate patients, two died of the disease within three years, 12 were living with the disease, and 123 were living and well. The three year cure rate was 87.2 per cent.

It is regrettable that so many patients were lost to follow up. From our experience in traeing patients it is evident that many were not convinced of the need for careful observation and refused to come in for periodic examination. Twenty of these lost to follow up were known to be clinically well from one to two and one half years after treatment. The large number of patients referred after treatment failure elsewhere weighed our recorded series with an abnormally large percentage of patients with advanced or complicated disease.

TABLE I. Results

Total cases		209	
Indeterminate			
Died of other disease	10		
Lost to follow up	78		
Discontinued treatment	4		
	92	92	
Determinate		117	
Died of disease	2		1.7%
Living with cancer (3 yrs.)	12		11.1%
Living and well (3 yrs.)	103		87.2%
	117		100.0%

Some advanced cases were particularly interesting. One elderly woman had a squamous cell carcinoma of her upper eyelid with extension into the orbit between the globe and the roof and fixed to both. This extension measured two by 2.5 centimeters in diameter and one centimeter in thickness. Another patient, an ardent Christian Scientist, presented an encircling carcinoma. This band of squamous cell almost completely surrounded the eye. (See Figures 1 and 2.) Another patient presented a malignant melanoma at the inner canthus. Our experience with melanomas of the skin parallels that reported from England in that some are radiosensitive. This lesion was treated with gamma rays from radium. Although it proved to be an insensitive growth, it was remarkedly reduced in size. The patient was then referred for surgical removal and died four years later of her disease.

Discussion

All the patients included in this report were attended by the author personally, providing consistency in evaluation and in technique. With few exceptions all patients suffering with malignant disease arising in the eyelid should make a complete recovery. Unfortunately, the patient is not disturbed when a small wart-like growth first appears because early disease is symptomless and enlargement is usually slow. Its true character may not be recognized when



FIGURE 1. Squamous cell cancer in Christian Scientist patient. Present 4 years.



FIGURES 2. After radium therapy. Patient died of recurrent disease 4 years later.

assistance is first sought so that time may be lost by ineffective measures.

A painless, slowly enlarging, firm, new growth appearing on the eyelids of a patient over 30 years of age should arouse suspicion of malignancy. Early lesions may be elevated or flat, they may or may not be ulcerated, but evidence of induration in the base or adjacent tissues is always present. The tactile sensation of firmness and the lack of inflammatory changes are significant diagnostic points. Because most lid cancers are basal cell, little danger is entailed in taking a biopsy and this should be done.

Early disease in the mid-portion of either lid may be eradicated by careful surgery, by x-rays or by radium therapy. Extensive disease or an early lesion located in either canthus presents a difficult surgical problem requiring multiple stage operations and plastic repair. Cancer about the eye, wherever situated, may be treated successfully with radium in most cases.

It has been reported that 1,000 x-ray roentgens delivered to the eye of a rabbit in one dose will produce microscopic evidence of equatorial cataract formation. It is quite possible that this total dose is equalled in the therapy of some lid scleral cancers but the dose is always spread over two or three weeks which in normal tissues produces much less reaction than if given at one time. In the patients of this series, as well as many others with lesions treated near the eye, no patient has suffered interference of normal vision due to therapy.

Summary

Two hundred and nine patients were treated with radium for cancer of the eyelid between the years 1934 and 1961. Although aware of the growth at its incipience many patients delayed therapy, believing the neoplasm to be of little consequence. Included in the group are 49 patients referred after failure of previous treatment elsewhere.

One hundred and seven patients were women, 102 were men. The average was 61.7 years with the youngest patient 32 years of age and the oldest 84. The size of the cancers varied from four millimeters to six centimeters in diameter and averaged 1.5 centimeters. Ulceration was present in one-fourth of the lesions. The tumors appeared with relatively the same frequency in the left eye as in the right. The lower lid was involved twice as often as the upper lid and the inner canthus three times as often as the outer canthus. Except for a few instances, radium therapy was employed, either utilizing the beta rays or the gamma rays. The three-year clinical recovery rate was 87.2 per cent.

Hypoprothrombinemia and Unsuspected Malignancy

David A. Sorg, M.D., James J. Hines, M.D.,
and Donald L. Kessler, M.D.*

Hemorrhage complicating anticoagulant therapy occurs in from two to nineteen per cent of patients.[1,2] However, it is unusual for bleeding to occur even in the presence of lowered prothrombin levels unless there is an associated area of compromised vascular integrity.[3]

Blood vessel injury may result from unsuspected malignancy, which the bleeding heralds. Prompt diagnosis is essential.

Case Reports

Case No. 1

A 78 year old white diabetic male, while daily receiving phenindione (Hedulin) for coronary artery disease, developed gross hematuria in April, 1957.

Physical examination revealed the following abnormalities: pallor of skin, mild obesity, 25 per cent transverse enlargement of the heart with a grade 3 aortic systolic murmur, a smooth nontender liver extending 8 cm. below the right costal margin, moderate enlargement of the prostate gland, bilateral varicose veins with scars of ancient varicose ulcers, and diminished arterial pulsations in the legs.

Laboratory data was as follows: Hemoglobin 12.5 Gms.; WBC 6,600 per cu. mm. with a normal differential count; hematocrit 38 per cent; urinalysis showed a trace of protein and 10-15 RBC per high power field; sedimentation rate (Wintrobe) 15 mm. in one hour; blood sugar 113 mgms. per 100 cc.; serum transaminase 14 units; cephalin cholesterol flocculation negative in 48 hours; total protein 6.6 grams with normal paper electrophoretic separation; alkaline phosphatase 3.6 Bodansky units; serum acid phosphatase 0.1 Bodansky units; bleeding time (Ivy) 4½ minutes; clotting time (Lee-White) 13½ minutes; platelet counts 182,000 and 195,000 per cu. mm.; clot retraction normal in 24 hours; whole plasma prothrombin time 23 seconds (control 13 seconds).

X-ray of the chest showed a 25 per cent transverse cardiac enlargement with an elongated and tortuous aorta. There was severe osteoarthritis of the thoracic and lumbar spines. X-rays of the stomach, gallbladder and colon were normal except for mild diverticulosis of the sigmoid colon. An excretory urogram failed to demonstrate any abnormality in the urinary tract.

Treatment: Phenindione was discontinued, but the whole plasma prothrombin time remained between 15 to 18 seconds. The patient was treated with whole blood, and oral and parenteral vitamin K without significantly changing the prothrombin time. The hematuria spontaneously subsided and the patient was discharged.

In April 1958 the patient was readmitted to the hospital because of extensive subcutaneous hemorrhages, occult blood in the stool, and microscopic hematuria. Although the patient had not received any anticoagulant therapy since the previous admission, his whole plasma prothrombin times measured from 17 to 20 seconds. No other alteration of the blood clotting mechanism was demonstrated and the patient was discharged taking 40 mgms. of Vitamin K orally daily.

In February 1959 the patient again had gross hematuria. The whole plasma prothrombin time was 19 seconds. A hematologic survey was similar to the initial study. A repeat excretory urogram showed an irregular filling defect about 1.5 cm. in size on the floor of the bladder. Two small polypoid masses were resected transurethrally. Pathologic diagnosis was transitional cell carcinoma without evidence of invasion.

Case No. 2

A 63 year old white female was hospitalized in March 1958 with an acute anterior myocardial infarction. She received phenindione for four weeks with whole plasma prothrombin time varying from 23 to 30 seconds. She suddenly bled vaginally. Pelvic examination showed slight cervical thickening, and blood exuding from the cervical os.

Laboratory data obtained at the time of the initial bleeding were as follows: hemoglobin 13.0 Gms.; white blood count 9,800 per cu. mm. with a normal differential; prothrombin time 25 seconds; bleeding time (Ivy) 4 minutes; clotting time (Lee-White) 11 minutes; clot retraction normal in 24 hours; total protein 6.2 gms. with a normal paper electrophoretic pattern; plasma fibrinogen 290 mgms. per 100 cc.; A Papanicolaou smear showed abnormal cells diagnostic of malignancy (Class 5, positive vaginal smear).

Anticoagulant therapy was stopped, and as soon as the patient's condition permitted, dilatation, curettage, and cervical biopsies were performed. The pathologic diagnosis was cervical adenocarcinoma (Schmitz Class II).

Case No. 3

A 64 year old white female was being treated with phenindione for an acute antero-septal myocardial infarction in September 1958. Her response to the drug was unpredictable and her whole plasma prothrombin

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times varied from 25 to more than 60 seconds. At the lowest prothrombin level vaginal bleeding suddenly occurred. Pelvic examination showed questionable slight uterine enlargement.

Laboratory data at the time of the bleeding were as follows: hemoglobin 11.5 gms.; white blood count 8,500 per cu. mm. with a normal differential count; bleeding time (Ivy) 3¼ minutes; clotting time (Lee-White) 9½ minutes; whole plasma prothrombin time over 60 seconds; plasma fibrinogen 330 mgms. per 100 cc.; clot retraction time normal in 24 hours; serum bilirubin 0.9 mgms. per 100 cc.; total protein 6.9 gms. with a normal paper electrophoretic pattern. A Papanicolaou smear showed abnormal cells suggestive of malignancy (Class 3. vaginal smear.)

Dilatation and curettage revealed the presence of a small endometrial carcinoma.

Discussion

Anticoagulant therapy is an accepted treatment for many disease states. Bleeding is the most common complication of such therapy, occurring most frequently in the skin, genito-urinary and gastro-intestinal tracts. Although spontaneous hemorrhages can occur with anticoagulant therapy, Stern and Dreskin[3] have shown that gross bleeding associated with hypoprothrombinemia ordinarily does not occur unless the integrity of the blood vessels is impaired. Saslow and Rosenberg,[4] Goodman,[5] Nichols,[6] and Henley et al[7] have reported similar cases of previously undiagnosed tumors incidentally discovered because of hemorrhage during anticoagulant therapy. A malignant tumor is only one of many diseases producing local vascular destruction, but because of its serious import, prompt diagnosis is imperative.

In the three cases presented the neoplasms were small, asymptomatic, and unsuspected on admission examinations. In each case hemorrhage occurred for the first time with lowered prothrombin levels, without other demonstrable impairment of the clotting mechanism.

In Case 1 an excretory urogram on the first admission did not demonstrate the bladder neoplasm. The presence of diabetes mellitus, chronic liver disease and multiple bleeding sites delayed our second evaluation of the hematuria, when the tumor ultimately was discovered.

Case 2 illustrates abnormal bleeding occurring with the prothrombin levels in the therapeutic range.

Case 3 emphasizes the fallacy of attributing bleeding to the depressed prothrombin levels alone, even when significantly lower than the normal therapeutic range.

It is well known that bleeding can occur spontaneously from a malignancy. Anticoagulant therapy may merely accentuate this bleeding tendency. Each bleeding episode should have the benefit of careful examination to determine the source. Such bleeding may herald the presence of an occult malignancy.

Summary

Hypoprothrombinemia in three patients signalled previously unsuspected malignant tumors with gross bleeding. It is suggested that malignant tumors may bleed earlier in the presence of an hypoprothrombinemia. Therefore, thorough evaluation of any bleeding occurring during anticoagulant therapy is essential.

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Post-Bulbar Duodenal Ulcer

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A post-bulbar ulcer is a peptic ulcer which occurs distal to the duodenal bulb. Ever since Heckford[1] first reported a case of post-bulbar duodenal ulcer in 1866, mounting evidence has indicated that this condition presents many features which differ from those of the usual duodenal bulb ulcer. For this reason, it is preferable to consider the post-bulbar ulcer as a separate entity.

We have observed ten cases of post-bulbar duodenal ulcer. The purpose of this paper is to review this condition, to present our findings, and to discuss the radiologic diagnosis of post-bulbar duodenal ulcer.

Anatomy

According to autopsy statistics, approximately ten per cent of duodenal ulcers occur in the post-bulbar region.[2,3,4] Since this incidence at autopsy is higher than is seen in radiological practice, it may be assumed that post-bulbar ulcers are being overlooked by the radiologist in some instances.

Males are affected by post-bulbar duodenal ulcers more frequently than are women. Nine out of ten of the cases in our study were men. Other investigators have found the incidence to be from 6½ to eight times greater in males than in females.[5,6]

The first part of the duodenum *(pars superior)* includes not only the duodenal "bulb," or "cap," but a post-bulbar segment as well. The bulb may occupy from as little as 20 per cent to more than 90 per cent of the pars superior—depending on the normal anatomical variations of this segment.

Since post-bulbar ulcers occur distal to the duodenal bulb, it is desirable to determine the extent of that bulb. Normally, the duodenal bulb measures about five centimeters in length. However, this measurement is unreliable, and even inaccurate, when inflammatory and cicatricial shortening are present.

A better criterion for measuring the duodenal bulb is the mucosal pattern. The bulb itself contains four longitudinal mucosal folds. The post-bulbar area can usually be identified by the presence of transverse mucosal ("Kerkring") folds. It should be remembered, however, that the immediate post-bulbar region sometimes contains longitudinal mucosal folds also. In such cases, therefore, the identification of ulcer location by means of mucosal pattern alone is not infallible.

Location of Post-Bulbar Ulcers

Of 248 cases of post-bulbar ulcer reported by Perry and Shaw[4], and Ramsdell et al[5], 83 per cent of the ulcers occurred in the first portion of the duodenum, 16 per cent in the second portion, and only one per cent in the third portion.

In the cases we saw, three ulcers were situated in the first portion, five in the second portion, and one at the junction of the second and third portions of the duodenum. Two craters were located at the genu superior.

Multiplicity

Multiple post-bulbar ulceration is not common. One of our cases had a crater of the pars superior, plus another crater at the junction of the second and third portions of the duodenum. Of 13 cases reported by Alvarez and Farinas[7], one showed a double (kissing) ulcer just be-

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FIGURE 1. (Case 1.) Typical post-bulbar ulcer. Marked narrowing of the lateral aspect of the second portion of the duodenum, with an ulcer crater noted medially.



FIGURE 2. (Case 2.) Typical post-bulbar ulcer. Narrowing at the junction of the first and second portions of the duodenum, with a large ulcer crater medially.

yond the bulb.

Two of the 10 post-bulbar ulcer cases reported by Lonergan and Kahn[8] were associated with duodenal bulb ulcer. Of the 53 cases reported by Barton and Cockshott,[6] two had duodenal bulb craters and two others showed deformed bulbs without demonstrable craters.

Clinical Findings

Pain. Abdominal pain, the most common symptom of post-bulbar ulcer, was present in all but one of our cases. The type of pain is that which is usually associated with the typical duodenal ulcer.[5,6]

In some patients, however, the pain is atypical.[9,10] Such atypical pain has little relationship to food, and shows a poor response to alkalis. Radiation of pain to the back may be a prominent feature.[5,6,8,9,11] Barton and Cockshott[6] mentioned two cases that were originally investigated by means of spine roentgenograms for a cause of back pain. Samuel[9] had three cases that were first studied for spinal disease. Another of Samuel's cases was originally believed to have coronary disease.

Invasion of the pancreas by the ulcer may result in symptoms of pancreatitis, and right upper quadrant pain may lead to an erroneous diagnosis of gall-bladder disease.[12]

Shaiken and Kanin[13] state that a differention between duodenal bulb ulcer and post-bulbar ulcer by symptomatology alone is not possible.

Bleeding and Obstruction. The incidence of bleeding in duodenal bulb cases is approximately 20 per cent. Bleeding occurs much more frequently with post-bulbar ulcers, however. This has been reported as ranging between 37 and 72 per cent.[7,11] A review of cases reported from 1910 to 1951 indicated that bleeding took place in 60 per cent of them.[11] We discovered bleeding in 70 per cent of our cases. The high incidence of bleeding in post-bulbar duodenal ulcer is believed to be due to the rich vascular supply of the superior pancreatico-duodenal artery.

Bleeding occurs most frequently as melena, although hematemesis also takes place. We found melena to be twice as common as hematemesis.

In associating the location of the ulcer with complications, Ramsdell was unable to find a significant difference in hemorrhage and obstruction between post-bulbar ulcers of the first portion of the duodenum, and those found in the second portion.

Although organic obstruction is not regarded as a common finding in postbulbar ulcer, some investigators have noted an incidence of obstruction as high as 20 per cent.[13] We found obstruction in only one of our cases.

Perforation and Other Findings. Free perforation is uncommon in post-bulbar ulcer cases.



FIGURE 3. (Case 3.) Ulcer originally overlooked. Examination of 3/3/61, during a bleeding episode. In spite of a two year bleeding history, a definite ulcer crater cannot be visualized. Note absence of significant narrowing of the duodenum.

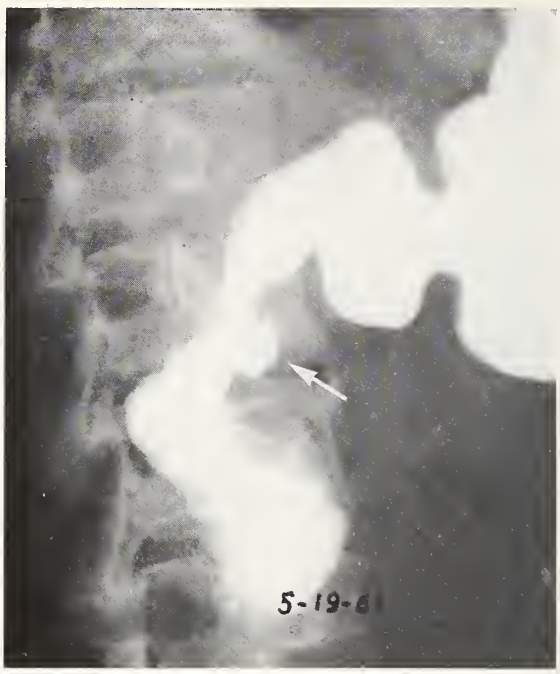


FIGURE 4. (Case 3.) On 5/19/61 a large ulcer crater is now demonstrable on the medial wall of the second portion of the duodenum. There is duondenal narrowing in this region, which can be suggested in retrospect on previous films.

This is probably due to the fact that these ulcers are usually posterior, and penetrate into the panereas.

Obstructive jaundice is an uncommon complication. It was present in one of our cases. The jaundice was due to inflammatory change in the region of the ampulla of Vater. Biliary fistula due to perforation into the common duct is a rare complication.[6]

Roentgenologic Examination

Ulcer Crater. The crater of a post-bulbar duodenal ulcer is usually located on the concave margin of the genu or along the posteromedial aspect of the upper descending duodenum. Less commonly, the crater may be situated in a lateral or an anterior site. The ulcer may vary in size from a few millimeters to several centimeters.

Unfortunately, the crater is not always visualized in roentgenologic examinations. There are perhaps several legitimate reasons why this is true. In two of our cases, for example, the crater could not be demonstrated because of marked spasm, and also because barium was not retained in the crater. In another case, the crater was not identified in the initial study because of its small size. This crater became more apparent in later studies, however, and could then be recognized in retrospect to the initial films. Two other cases, in which ulcer craters were present, were misinterpreted as representing diverticula.

Other investigators have noted non-visualization of the crater in 34 to 50 per cent of the cases studied.[5,8] In the series of Ramsdell, et al,[5] craters were not identified in 34 cases at the first examination. Of these, however, 30 were demonstrated on the second study. The crater was recognized on the third examination in the remaining four patients. Eventually, the ulcer crater was visualized in all of their 99 cases.

Narrowing. Narrowing of the duodenum is the most common finding in post-bulbar duodenal ulcer. This narrowing, which may be due to spasm or to fibrosis, usually takes the form of an asymmetrical indentation in the duodenal wall lying opposite the ulcer. This finding is

therefore usually noted on the lateral wall of the duodenum. Such localized narrowing may simulate neoplastic disease, especially when the ulcer crater does not visualize.

Although the duodenal narrowing associated with post-bulbar ulcer does not usually produce organic obstruction, some observers claim to have noted such obstruction in as many as 25 per cent of their cases.[14] We observed organic obstruction in only one of the cases which we studied.

Perforation. Free perforation of a post-bulbar ulcer is an unusual complication, presumably because most such ulcers are posterior and tend to become walled off within the pancreas. In one of the cases of Lonergan and Kahn,[8] the perforation was due to an ulcer which was situated on the anterior wall of the second portion of the duodenum.

Widening of the Duodenal Loop. Since the post-bulbar ulcer may be in intimate relationship with the pancreas, inflammatory change in the pancreas may occassionally result in widening of the duodenal loop—or it may exert extrinsic pressure on the inner margin of the duodenal loop. This might lead to an erroneous diagnosis of primary pancreatic disease, especially if the post-bulbar ulcer crater is not visualized.

Other Findings: Other abnormalities may be noted which are ineonstant and non-specific. These include pylorospasm, spasm of the duodenal bulb, and edema of the mucosal pattern of the duodenum in the region of the ulcer.

Positioning and Technic in Examination: The proper technic of examination is essential in the search for post-bulbar ulcers. The upright position is unsatisfactory, since the barium passes through the post-bulbar area too rapidly for adequate study.

The pars superior of the duodenum courses posteriorly and may therefore not be well demonstrated in frontal or oblique views. Thus, the lateral projection is of great value, and is usually the best means of visualizing the post-bulbar first portion of the duodenum. "Foreshortening" is at a minimum in the lateral position.

The projection of choiee, therefore, is the recumbent position, with the patient lying on the right side. This projection should be obtained in every fluoroscopic and radiographic examination. This position may be modified by a slight rotation toward the prone or supine position, as determined fluoroscopically.



FIGURE 5. (Case 4.) Examination of 4/11/61. In spite of a history of pain and melena of 6 months' duration, the post-bulbar ulcer is not visualized, due to spasm and incomplete filling of this region. This type of spasm must not be disregarded, and is an indiction for intensive study of the duodenal loop.

The first and second portions of the duodenal loop must be completely visualized before the examination ean be considered satisfactory. Routine study of the duodenum in such a fashion is the most important method of demonstrating post-bulbar ulcers.

Differential Diagnosis: A duodenal diverticulum may simulate a post-bulbar ulcer. The diverticulum may be identified by its smooth contour, narrow neck, and by mueosal folds entering the sac. *Spasm is absent.*

Malignant tumors of the duodenum may present some diagnostic problems. If a mass ean be demonstrated, correct diagnosis is not too difficult. Most tumors of the duodenum are periampullary, whereas the post-bulbar ulcer is usually higher in position. Lack of response of a neoplasm to medieal management is also a differentiating feature.

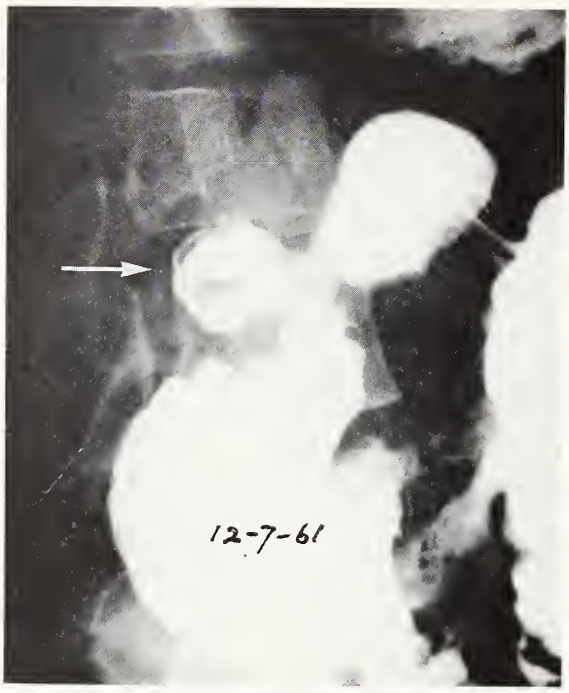


FIGURE 6. (Case 4.) Eight months later, on 12/7/61, a large ulcer crater is noted distal to the duodenal bulb. Note the atypical location of the crater on the lateral margin of the duodenum.

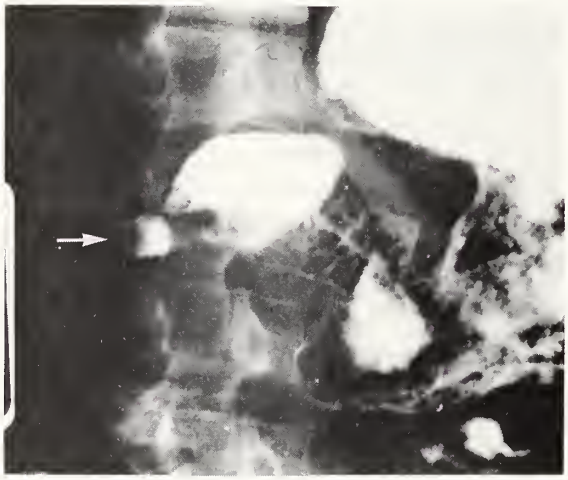


FIGURE 7. (Case 4.) After twelve days of medial management, the ulcer is 50% smaller.

Treatment

The treatment of uncomplicated post-bulbar ulcer is medical.[7] Medical management, however, is often disappointing.[6] Since most cases are complicated by bleeding and/or medical intractability, surgical treatment usually ensues. The surgical procedure is essentially the same as for ulcer of the duodenal bulb. Seven of our ten cases were treated surgically.

Case Reports

The following case reports correspond to the cases which are illustrated in this paper.

Case 1

G.B., Negro male, age 43, was admitted with a history of intermittent abdominal pain of six years' duration. This had become considerably worse during the preceding three weeks. Melena had been noted for two weeks. Hemoglobin was 34 per cent, red blood count 2.47 million. Roentgen studies showed an irregularity of the mucosal pattern in the second portion of the duodenum, possibly due to extrinsic pressure. The roentgen examination was repeated nine days later. A constant irregularity of the second portion of the duodenum was noted. These findings suggested an ulcerative inflammatory process. The patient was discharged on medical management. He was readmitted three years later, complaining of epigastric pain and melena. Two roentgen examinations were performed. On the first study an ulcer crater was noted just beyond the genu superior, on the medial wall of the duodenum. There was an incisura on the lateral wall of the duodenum. Four days later, spasm was noted, but the crater was not re-demonstrated. The post-bulbar ulcer was verified at surgery. The patient expired on the fifth post-operative day.

Case 2

F.D., a white male, age 60, was brought to the hospital in a stuporous condition. Physical examination revealed a stuporous patient, but was otherwise non-contributory. Melena was noted. Hematocrit was 28 per cent. Barium meal revealed a large post-bulbar ulcer crater at the genu superior. There was widening of the duodenal loop. The patient's sensorium improved, and he signed his release, to be followed on medical management.

Case 3

R.S., a 37 year old white male, was admitted because of coffee-ground hematemesis of several hours' duration. Hematemesis had occurred several times during the past two years, but no definite gastrointestinal diagnosis had been made, despite hospitalization. The patient was diabetic and was frequently out of control. He had been treated for tuberculosis, which was thought was related to the bleeding. There was never any abdominal pain or tenderness.

Roentgen study of the upper gastrointestinal tract was interpreted as a "diverticulum of the second portion of the duodenum." The bleeding subsided, and the patient went home, only to return after two months with hematemesis. Uncontrolled diabetes was also present. The roentgen examination at this time revealed a two cm. ulcer crater in the medial wall of the upper

portion of the descending duodenum. There was narrowing of the lumen of the duodenum in this area. The patient again left the hospital. Seven months later he returned because of recurring hematemesis. At surgery, the site of the ulcer was localized to the posterior wall of the mid-descending duodenum.

Case 4

S.R., Negro female, age 31, complained of epigastric pain of six months' duration. The pain was sharp, intermittent, non-radiating, and occasionally cramp-like, lasting two to three minutes. This pain, which would occur at any time, was usually relieved by food, milk, and antacids. There was occasional emesis (non-bloody). Melena had been noted for one week. Physical examination revealed mild tenderness in the right upper quadrant. The patient had been in the hospital eight months previously with similar complaints. The initial roentgen study at that time did not reveal the ulcer, because of spasm and non-filling of the second portion of the duodenum. At the present study, the ulcer was readily visualized. The crater was on the lateral wall of the upper portion of the descending duodenum. The patient was placed on medical management for twelve days. Repeat X-ray studies showed the crater to have diminished in size from 28 mm. to 15 mm. in diameter.

At surgery, a large post-bulbar ulcer was found, for which vagotomy and gastric resection were performed.

Summary

The post-bulbar duodenal ulcer is characterized by a high incidence of bleeding and a low incidence of obstruction and perforation. Clinical symptoms may resemble duodenal bulb ulcer, but atypical symptomatology is often present.

Because of the frequent occurrence of bleeding (70 per cent), early radiologic detection is important. Unfortunately, these ulcers are difficult to visualize. They may, therefore, be overlooked.

Careful fluoroscopic observation and roentgenological visualization of the first and second portions of the duodenum is essential to proper diagnosis. This projection of choice is the recumbent position, with the patient lying on his right side. The projection should be obtained routinely during the fluoroscopic and radiographic examination.

The responsibility for early diagnosis lies chiefly with the radiologist, who must make a determined effort to visualize the post-bulbar area in all upper gastrointestinal studies.

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Applications For Research Grants To Be Considered by ACS

Dr. Israel Davidsohn, M.D., has announced that the Research Committee of the American Cancer Society, Illinois Division, will consider applications for research grants at its next meeting. This will take place on Thursday, May 28, 1964. Applications may be obtained by contacting the Executive Director, American Cancer Society, Illinois Division, Inc., 37 So. Wabash Avenue, Chicago, Illinois. The telephone number is 372-0471. Deadline for receiving applications to be reviewed at the May 28th meeting is April 21, 1964.

Idiopathic Koilonychia (Spoon Nails) in a Child With Hemoglobin S-C Disease

Kewal K. Jain, M.D. and Steven O. Schwartz, M.D.

Koilonychia, sometimes more commonly called "spoon nails" because the nails present a concave shape, is one of the interesting abnormalities of nails in man.[1] Although the condition was first described by Ball in 1874, he did not give the disease a name.[2] Crocker, reporting another case in 1896, suggested the name "spoon nails."[3] In 1900 Heller designated the name "koilonychia" (*G. Koilos,* hollow + *onyx,* nail) to the deformity.[4] Mackee thought that koilonychia might be fairly common but that patients did not seek medical advice unless cosmetically perfect nails were important to them.[5]

Koilonychia may be either congenital or acquired. Congenital koilonychia may be limited to the fingers or toes or it may involve both. Anomalies of other epidermal structures may coexist with the congenital form.

Acquired Koilonychia is usually associated with a hypochromic microcytic anemia which is due to iron deficiency. Hypochromic anemia, however, is not always specific for iron deficiency and may occur in certain other conditions, such as thalassemia.

The purpose of reporting our case is twofold: (1) Our patient had a hypochromic anemia due to hemoglobin S-C disease; and (2) the koilonychia was not related to iron deficiency.

CASE REPORT

H. C., a nine-year old Negro boy was referred for evaluation of an existing anemia. Occasional minimal nose bleeding had occurred during the preceding year.

Examination revealed a well developed, well nourished boy with mild pallor but in no distress. Scleras were mildly icteric. The teeth were normal; the skin was of a fine texture and normally pigmented. The spleen was firm and its lower border was 2.5 cm. to three cm. below the left costal margin. The liver was not palpable. Heart and lungs were normal.

All the fingernails except those of the ring finger were spoon shaped (Fig. 1. and Fig. 2.). The nails of the great toe and third toe were spoon shaped bilaterally. The nails that were excessively deformed were concave; that is, the nail as a whole was depressed with the lateral and distal portion everted, or turned upward, producing a spoon or cup appearance. Margins were cracked (Fig. 3). Brittleness, striations and leukonychia were accompanying conditions. Pressure on the nails did not produce pain and the nails were free from inflammation. Slight subungual hyperkeratosis was present at the distal end of the nails. The spoon-shaped nails had been present since early childhood.

One brother also had had spoon nails in childhood. The condition disappeared within three years without any therapy, although residual nail changes still can be identified (Fig. 4). Both parents had normal nails and none of the other four siblings or relatives had abnormal nails.

Splenomegaly, present in our patient, was not observed in any other member of the family.

Clinical Laboratory Examination: Analysis of the blood showed hemoglobin 71 per cent (10.9 Gm.); red blood cell count 5.27 million per cu. mm.; color index 0.67; reticulocyte count 8 per cent; white blood cell count 6,700 per cu. mm.; 62 polymorphonuclear cells; 22 lymphocytes; 6 eosinophils; 9 monocytes; 1 basophil; 1+ anisocytosis; 3+ targeting; 1+ toxicity; 1+ hypochromia; platelets were normal. Sickle cells were seen, but there was no microcytosis.

Urinalysis showed specific gravity 1.012, pH 5.5. Urobilinogen was 3+. Sugar was absent and microscopic examination was negative.

There was no blood in the stools, nor were ova or parasites found.

The Kahn reaction of the blood was negative. Protein bound iodine was within normal limits; serum iron 55 gamma (Peterson method) (normal 50-150); iron binding capacity 165 gamma (normal 144-322); total iron binding capacity was 220 gamma; saturation was 25 per cent.

Hemoglobin electrophoresis on paper showed S-C hemoglobin.

The hemoglobin patterns of the other members of the family are shown on Chart 1.

From the Hekteon Institute for Medical Research of the Cook County Hospital and Northwestern University Medical School, Chicago, Illinois.



FIGURE 1. Fingernails of patient, showing extensive involvement of all but ring fingers.



FIGURE 2. Koilonychia of the finger nails.



FIGURE 3. Koilonychia with additional cracking, brittleness and striations of the nails.



FIGURE 4. Patient's brother. Koilonychia present earlier has disappeared.

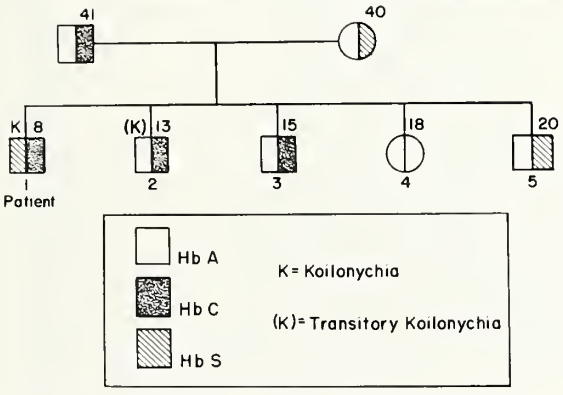


CHART 1. Hemoglobin patterns in members of the family.

Marrow Examination. Marrow obtained from the posterior iliac crest was markedly hypercellular. The megakaryocytes were normal. The nucleated RBC: WBC ratio was approximately 5:1. Erythropoiesis was normoblastic. Granulopoiesis showed slight toxicity. Eosinophils were slightly increased. Iron was present in more than normal amounts.

The marrow changes were compatible with compensated hemolytic anemia.

Barium enema and post evacuation air contrast films did not reveal evidence of any gross abnormalities.

The dermatologist reported no evidence of fungal infection of the nails.

The patient received iron therapy for six months without increase in hemoglobin or reticulocytes and without improvement in the koilonychia.

Discussion

Koilonyehia is eharaeterized by an everted distal edge, flat lateral margin, and a spoon-like eentral eoneavity of the fingernail. Any number of fingernails may be affected and in varying degree. Assoeiated ehanges inelude exaggerated longitudinal striations, thinning and brittleness. The latter ehanges are also often observed in eases of iron defieieney anemia in which typieal koilonyehia is laeking. A case with koilonyehia of the toenails has been observed by Eddow, eited by Croeker.[3]

Most observers have remarked that in cases under their observation in which the anemia was sueeessfully treated with iron, the nail ehanges disappeared. Waldenstrom and Hallen[6] have reported three eases of koilonyehia without assoeiated anemia, in two of which the nails beeame normal after iron therapy.

Of 180 cases of "idiopathic" hypochromic anemia in adults, covered in 12 reports, koilonychia was reported in 27.[7-9] Studies were not carried out in those cases to determine serum iron level and iron content of the marrow. However, there was a good response to iron therapy. In view of this evidence and the present state of knowledge of "idiopathic" hypochromic anemia, many of these cases were probably not idiopathic but were due to iron deficiency. Our case does not fall in this group.

Most of the recorded cases of koilonychia were apparently sporadic in origin and usually developed in relation to some environmental factors. Familial cases have also been reported. Although Gates[10] assumed a dominant inheritance in these pedigrees, the genetics of this abnormality has not yet been fully elucidated. Yoshitoshi and co-workers[1] found large Japanese kindred cases: 36 affected members extending over five generations. This seems to show that this congenital abnormality is due to a simple dominant autosomal gene.

The expression of the abnormality differs in different cases. In our case, the hereditary aspect seems strong for the following reasons:

1. Lack of acquired causation or evidence of iron deficiency.

2. The presence of koilonychia since early childhood.

3. History of similar nail changes in one of the siblings.

There seems to be little, if any, indication of a relationship between koilonychia and hemoglobin C trait or SC disease. We have not found reports of koilonychia in patients with S, C, or SC hemoglobinopathy, nor have we in the past encountered the condition in our studies of a large number of patients with these conditions. Thus, in the present case, the relationship of the koilonychia to S-C disease appears to be a coincidental one.

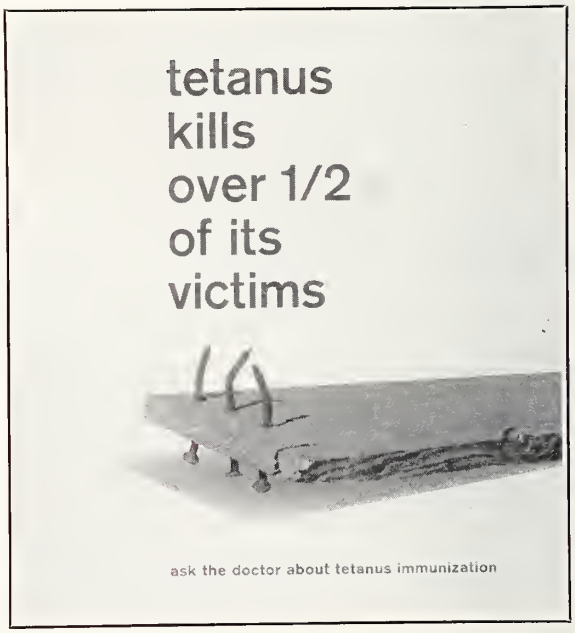
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Campaign For Nationwide Tetanus Immunization

In support of the A.M.A.'s current campaign for nationwide tetanus immunization, Eli Lilly and Company is making various promotional materials available to physicians. The illustration on this page, for example, portrays the easel poster that has been specially designed for display in physicians' offices and waiting rooms. Also available are promotional pieces that are of particular interest to industrial physicians, and to industry executives interested in the welfare of their employees.

Starting in December, 1963, Lilly medical service representatives have been distributing such materials to interested physicians and industrial concerns.

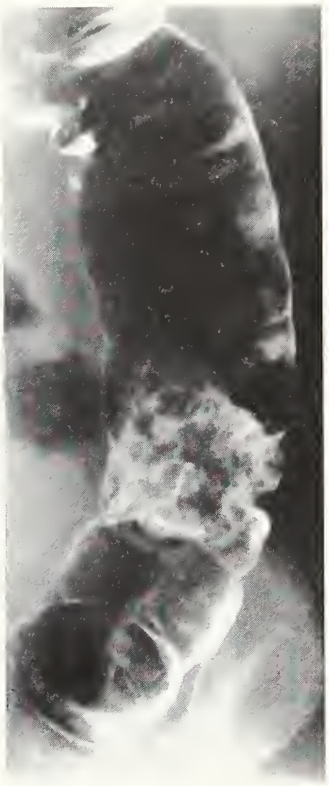


The View Box

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital
Chicago, Illinois



Film 1.



Film 2.

Patient was a 59 year old, white female, who entered with a history of two bright red bloody bowel movements on different occasions. A careful history revealed that her "diarrhea" was a passage of considerable mucus in her stool, particularly on arising.

Physical examination was unremarkable. Sigmoidoscopic examination was normal up to 21 cm.

What is your diagnosis?
1) Carcinoma of the descending colon
2) Benign villous adenoma
3) Adenomatous polyps

(Continued on page 255)

Intermittent Cyclophosphamide* In Disseminated Neuroblastoma

Robert D. Weber, M.D., *Rockford, Illinois*

Neuroblastoma is most frequently treated by surgery, radiation or a combination of both. Only recently has significant palliation by chemotherapy been described for patients whose disease is widely disseminated.

Case Report

A nine year old white female was referred for orthopedic evaluation because of back pain noticed after a fall at school. A chest x-ray (Fig. 1), taken November 12, 1962, showed a right posterior paramediastinal mass, and neurologic examination revealed minor sensory changes in the lower extremities. The remainder of the physical examination was normal. Myelogram showed a complete block in the mid dorsal area. The diagnosis was felt to be a "dumbell" neurogenic tumor. Urinary catecholamines were normal.

A dorsal laminectomy was carried out on November 19, 1962, with partial removal of a very vascular extradural tumor. This was followed by 2500 roentgens of Cobalt radiation to the mediastinum. There was minimal change in the appearance of the chest x-ray over subsequent weeks.

Severe pain in the right hip and anemia (hemoglobin 5.8 grams) resulted in rehospitalization in December, 1962, but x-rays were normal and no definite evidence of disseminated disease was obtained. She responded well to blood transfusions and salicylates. On February 7, 1963, the mediastinal mass was excised (Fig. 2) along with a portion of the chest wall. The removal was felt to be incomplete in the region of the sixth and seventh intervertebral foramen. Portions of material from both the intraspinal and mediastinal areas were reviewed by Doctor Arthur Purdy Stout and Doctor James K. Kernohan in consultation. They concurred in the diagnosis of neuroblastoma.

One month later she required another 1500 c.c. of blood because her hemoglobin dropped to 5.1 grams. At that time she was started on 3 mg./Kg. per day oral Cyclophosphamide. During the next two months she developed frontal headaches, nausea and vomiting. She began to lose weight. Proptosis and periorbital ecchymosis of the right eye developed as did bilateral papilledema. Diplopia was noted. The hemoglobin had again fallen from 12.0 to 7.7 grams and the white blood count was 2500. Skull x-rays showed numerous punctate



FIGURE 1



FIGURE 2

*Cytoxan—Mead Johnson and Company.

radiolucencies in the parietal bones.

She was now changed to intermittent intravenous Cyclophosphamide therapy, 600 mg. every ten days, (30 mg./Kg.). Improvement was dramatic. She has gained seven pounds. The proptosis, diplopia and periorbital ecchymosis disappeared within one month of institution of this therapy.

The papilledema disappeared within two months and the hip pain, which had confined the child largely to bed and a chair, disappeared. She returned to school on a full time basis. Hemoglobin has risen to 12 grams. The white blood count has remained in the vicinity of 3,000. The therapy has been continued since May 15, 1963, but in the last two months the dosage was reduced to 600 mg. every two weeks. Aside from nausea and vomiting on the day of injection, no toxic manifestations have been noted.

Comment

Cyclophosphamide falls into the group of alkylating agents of which nitrogen mustard was the prototype. It has been used most frequently in the treatment of lymphomas and certain leukemias. There have been comparatively few reports of its use in the treatment of neuroepithelial tumors.[1-4,7-10]

The drug is probably most frequently administered orally on a daily basis. Various investigators suggest dosages of from 2-8 mg./Kg. per day. It has reeently been suggested that intermittent single doses of 20-40 mg./Kg. given at 10-20 day intervals are more effective and produce fewer side effeets. Leukopenia of 1500-2000/eu.mm. is often said to refleet maximum dosage. In addition to leukopenia, thrombocytopenia, anemia, gastrointestinal disturbances and alopecia capitus may also occur.

Summary and Conclusion

A ease is reported of dramatie relief of symptoms with intermittent intravenous Cyclophosphamide therapy in a child with disseminated neuroblastoma. This patient showed no clinical response to daily oral administration of the same drug.

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The View Box

Diagnosis: Benign villous adenoma.

The charaeteristie roentgen appearance of a soap bubble appearanee of the polypoid type of lesion is highly suggestive of villous adenoma. The usual loeation for 80 per eent of these tumors is in the reetum or reeto-sigmoid. In this ease, the lesion is in the deseending eolon.

Air eontrast examination of the eolon demonstrates the soap bubble appearance much more readily than ordinary barium enema examination.

These tumors are benign and represent be-

(Continued from page 253)

tween 2 to 8 per cent of adenomas of the colon and do not exceed 3 per eent of all colon tumors. They can beeome malignant and do so more readily than adenomatous polyps. They are seen in the 5th and 6th deeades of life and give a history of pseudo-diarrhea due to passage of mueus. Reetal bleeding and eleetrolyte depletion ean oeeur.

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The History of Neurology in Chicago

ROLAND P. MACKAY, M.D., *Chicago*

This is the third installment of an informative history of neurology not only in Chicago as the title would indicate but throughout the state and the nation. In a delightful and interesting style, Dr. Mackay paints a picture of the growth of neurology as seen against the times in which it was practiced—a story of a city and specialty growing together.

Shobal Vail Clevenger was born March 14, 1843 in Florence, Italy to a successful sculptor who, on his way home, died of tuberculosis and was buried at sea. Clevenger's was a wandering life of startling versatility which led him as a child to New Orleans, where he survived yellow fever in 1853, to St. Louis where he worked as a youthful bank messenger and collector, to Colorado, to New Mexico, and to the Union Army in the Civil War, where he served in the Enigneer Corps. Eventually he commanded a regiment. After the war he married and went to Montana where he was hotel keeper, probate judge, court commissioner and revenue agent, beside making meteorological observations for the Smithsonian Instiution. With increasing scientific skills he qualified as a civil engineer, surveying wide acres in the Dakotas, and building the first telegraph to link Yankton with civilization. But after a disappointing experience with bureaucrats which disgusted him with politcians, he turned to medicine and came to Chicago where he graduated at the Chicago Medical College in 1879, already 36 years of age. After a long stint at general practice in this city he was appointed through the grace of the gambling political boss, Mike McDonald, as pathologist at the Cook County Insane Asylum at Dunning, mentioned above as described by Lyman. There, for the first time in the history of that institution, he wrote careful case reports and pathological studies which were later published in the Chicago Medical Journal and Examiner in 1884. He was shocked by the graft, corruption and inhumanity that he witnessed. At that time attendants stole the patients' food, clothes and bedding, the drug room became a saloon and mechanics had keys to the female wards, with the result that illegitimate babies were born in the hospital. Against these abuses Clevenger became an aggressive warrior. In his battle he wrote many articles to the newspapers, expos-



Shobal Vail Clevenger
(1843-1920)

Read before the International College of Surgeons, Chicago, Illinois, March 19, 1963. Excerpts of this article appeared in the Journal of the International College of Surgeons, August, 1963 under the same title.

Professor of Neurology, Northwestern University Medical School, and Senior Attending Neurologist, Chicago Wesley Memorial Hospital.

*For much of the material here presented on the general history of Chicago, I am deeply indebted to Emmett Dedmon's *Fabulous Chicago*.[1]

ing evil and demanding reform. Of these the most famous was his "Appeal to Physicians," published in the newspaper, Chicago Inter Ocean. On the night of the appearance of this article a bullet was fired into Clevenger's house, barely missing his wife and daughter. Thereupon he resigned as pathologist at the Cook County Insane Asylum. But at a meeting of the State Board of Charities he denounced the County Commissioners to their faces and by name. Many others joined him in the columns of the city press, and finally the State's Attorney brought suit against the evil-doers and obtained convictions which placed the guilty behind bars. For his fight with intrenched graft Clevenger earned the sobriquet "Don Quixote of Psychiatry," applied to him by his biographer, Victor Robinson.[15]

For a time, he was neurologist at the Alexian Brothers and Michael Reese Hospitals and lectured on anatomy at the Chicago Art Institute, on physics at the College of Pharmacy and on medical jurisprudence at the College of Law. From boyhood he was an inventor of singular ingenuity, producing a self-reeling hose cart, a boot blacking machine, a sun-dial to give automatic clock-time, and a simplified typewriter, none of which reached the market. But his demonstration model of the brain was in wide demand.

In his earliest writings, Clevenger demonstrated the enormous range of his interests, including engineering, astronomy and surveying. In 1879, the year of his graduation in medicine, he published an essay on cerebral topography in which he described the inferior longitudinal occipital sulcus, later named "Clevenger's Fissure" by Burt G. Wilder. In 1880 he contributed a Saturday Science Column to the Chicago Tribune and in 1881 he wrote "Nerve Cells and Their Function," a subject which formed his American Neurological Association thesis. One of his most penetrating observations was presented in his "Disadvantages of the Upright Position" which appeared in *The American Naturalist* in January 1884. In this paper he explained that valves are found only in those veins which, when men is considered as proceeding on all fours, conduct blood against gravity, while those carrying blood horizontally, such as the vena cava and the spinal, iliac, hemorrhoidal and portal veins, have none. Also in 1884 he published his book, *Comparative Physiology and Psychology* and in 1889 his famous work, "Spinal Concussion." This latter led to a diagnostic fad apparently as popular as the modern "whiplash" cervical injury and much more ridiculed. Clevenger named this "spinal concussion" Erickson's Disease and attributed the symptoms to mechanical injury to the spinal sympathetic nerves. But others contended that this "disease" was merely malingering for the cash settlement—a contention to which time has granted sympathy. But for years Clevenger defended his concept against all opponents and skeptics.

Throughout his whole life Clevenger wrote voluminously on the widest topics—even linguistics. His largest book was in two volumes published in 1898 and entitled *Medical Jurisprudence of Insanity.* Largely intended for lawyers, it is discursive and poorly arranged, though wise and aphoristic in many sections.

In 1893 the new Governor of Illinois, Altgeld, startled Clevenger, quietly practicing at 70 State Street, by appointing him to succeed Richard S. Dewey as Superintendent of the Eastern Illinois Hospital for the Insane, at Kankakee. In that position he appointed, as pathologist, Adolph Meyer, who there began his distinguished career. At Kankakee he again became a warrior for righteousness and planned great reforms, as at Dunning, but within 3 months he was given leave-of-absence because of "nervous exhaustion" and never returned to his post. Thereafter his local career declined, but he continued to occupy a prominent place on the national scientific scene, keeping in touch with many notable biologists and naturalists, such as E. D. Cope, Joseph LeConte in Philadelphia, and the great neuroanatomist, E. C. Spitzka, of New York. In 1903 he produced an imposing book entitled *The Evolution of Man and His Mind.* But his life trailed off into less activity and more reminiscence until his death in 1920.

In summary, Clevenger was in many respects an erratic genius, often brilliant, of astonishing versatility, but given more to grandoise generalization than to patient constructive labor as a basis for his conculsions. He was a valiant warrior for truth and decency, whose

generous impulses excite our admiration.

Harold N. Moyer, born at Canajoharie, New York, in 1858, graduated from Rush Medieal College in 1879 and soon became assistant physieian at the Cook County Hospital, the psyehopathic department of which was called "The Cook County Crazy House." In 1881 he beeame assistant physieian at Kankakee under Dewey for 2 years, after whieh he set up his private office on west Madison Street in Chicago and began his long eareer of teaehing neurology and psyehiatry at Rush in an aseending series of positions from leeturer on histology to Professor of Diseases of the Nervous System and Chief of the Neurologieal Clinie. Coneurrently, he was Professor of Nervous Diseases at the Postgraduate Medieal Sehool, neurologist at the Cook County Hospital and lecturer at the Kent College of Law. He was early interested in medieo-legal questions and became the best and best known medieo-legal expert in Chieago. In the latter years of his life he was medieal advisor to several large corporations, but was seldom on the witness stand. (One may assume that his ehief duty in this respeet was protection of the eorporation against liability.) He wrote early and voluminously, mostly on neurology, psyehiatry and forensie medieine, but his interests were also historieal and he eontributed interesting articles on early neurologieal figures like Jewell. For 12 years he was editor of the publieation *Medicine*. He was a member of many organizations, a eharter member of the Chieago Neurologieal Society, and its president in 1916-17. He served on the staffs of Columbus, St. Luke's and Merey Hospitals. Though his interests embraeed both neurology and psyehiatry, the latter probably dominated his thoughts; the last paper he presented before the Chieago Neurological Soeiety was in Deeember 1922, entitled "The Psyehoanalysis of a Male Flirt." He died a year later, on December 14, 1923.

Oscar Augustus King was born in Peru, Indiana February 22, 1851, studied medieine first in 1873 under Dr. Henry Palmer, the Surgeon General of Wiseonsin, and under Professor Louis A. Sayer, of New York. He graduated from Bellevue Hospital Medieal College in New York City in 1878. He then came west to Wiseonsin where he was first Seeond, then



Harold N. Moyer
(1858-1923)

First Assistant Physieian at the Wiseonsin State Hospital for the Insane at Madison 1879-82. But in 1880 and 1881, on leave-of-absenee, he studied neurology and psyehiatry at the University of Vienna under Meynert, Leidersdorf, Weiss and Benediet. A year after his return he resigned in 1882 to take the ehair of mental and nervous diseases at the College of Physicians and Surgeons of Chieago, where he gave the first leeture in the medieal eurrieulum. He was a strong faetor in seeuring the ineorporation of the old College of Physicians and Surgeons into the University of Illinois, by lease in 1897 and by deed on Mareh 6, 1913. His title was ehanged in 1894 to Professor of Neurology, Psyehiatry and Clinieal Medicine. He beeame viee-dean in 1900. In the meantime he was also Professor of Neurology at the Illinois Postgraduate Medieal Sehool.

But his interests were ehiefly psyehiatrie, and, like many other neuropsyehiatrists, he broadened his influenee (and ineome?) by establishing private sanitaria for nervous patients. He founded the Oakwood Retreat in 1883 in Lake Geneva, and the Lake Geneva Sanitarium in 1896, amalgamating the two in 1901, remaining direetor of the combined institutions. He was a member of the Advisory Medical Board

of the Cook County Institutions in Dunning in 1896, and appointed Pathologist and Consultant Neurologist to the Wisconsin State Charitable and Penal Institutions in 1897. At his death on September 11, 1921 he was Professor Emeritus of Neurology and Psychiatry at the University of Illinois College of Medicine.

James George Kiernan was born in New York June 18, 1852 and graduated at the New York University College of Medicine in 1874. He at once became Assistant Physician at Ward's Island Hospital, later the New York State Insane Hospital, and remained in that position until 1878. He was an officer of the New York Neurological Society and was active in the reforms in neurology and psychiatry brought about by that society. From 1881-2, he was Assistant Professor of Nervous and Mental Diseases at the Chicago Medical College, now Northwestern University Medical School. About 1884 he was made Medical Superintendent of the Cook County Insane Asylum at Dunning and suffered grievously with Clevenger, his pathologist there during their efforts at scientific and humanitarian reform. Open defiance nullified their efforts; Kiernan himself was knocked down by an attendant, struck by an engineer and choked by a night watchman when he attempted even mild discipline of these functionaries. When the entire medical staff requested the discharge of a brutal housekeeper, they were invited to go to hell! Kiernan resigned his position as Superintendent in 1889 —that he held out so long is a tribute to his tenacity and courage.



James George Kiernan
(1852-1923)

Kiernan was an expert in forensic psychiatry and Professor of that specialty in the Kent College of Law in Chicago from 1890-1902. He was witness for the defense in the famous trial of Guiteau, the assassin of President Garfield, in 1881, holding that the accused was insane, and in the Mooney trial in 1884, and testified in many others. But, a timid, academic scholar, he was easily confused and upset on the stand by clever lawyers, as amusingly related by Victor Robinson in his *Don Quixote of Psychiatry.*[15] He lived a long life, considering his personality and harassments, dying with diabetes in 1923 at the age of 71.

Dr. Ryan Re-elected as President, Illinois Society for Medical Research

Dr. Andrew H. Ryan, dean of students at The Chicago Medical School and professor of pharmacology and therapeutics, has been elected to his fifth one-year term as president of the Illinois Society for Medical Research. Dr. Ryan is also a member of the executive council of the National Society for Medical Research.

Other re-elected officers were **Dr. John H. Annegers,** assistant professor of physiology at Northwestern University, vice president; **Dr. Joseph A. Wells,** professor and chairman of the department of pharmacology at Northwestern University, treasurer; and **Dr. Nathan R. Brewer,** associate professor of physiology at the University of Chicago, secretary.

Newly named to the executive committee was **Dr. Howard Weisberg,** research associate at the cardiovascular institute of Michael Reese Hospital and Medical Center. Two incumbent members were re-elected to the executive committee. They were **Dr. William C. Dolowy,** administrator of the medical research laboratory at the University of Illinois; and **Dr. Yvo T. Oester,** professor of pharmacology at Loyola.

Announcing *Preview of ISMS Convention Program*



ISMS Convention

May 17-21, 1964

Sherman House Chicago

Some sections have finalized the schedules for the programs that they will present at the 1964 ISMS Convention. Listed below are some previews of these programs.

Eye, Ear, Nose and Throat Section

The EENT Section of ISMS will present an all-day program on Thursday, May 21. Four out-of-state authorities will be featured as guest speakers. The program for this section follows:

9:00 A.M. Alex E. Krill, M.D., Chicago, Illinois; *Tonometric and Tonographic Features of Early Wide Angle Glaucoma.*

9:15 A.M. George S. Pap, M.D., Rockford, Illinois; *Application of Surgical Procedures in Eyelid Surgery.*

9:30 A.M. H. J. Drell, M.D., Rockford, Illinois; *The Psychiatrist and the Eye.*

9:45 A.M. Jay H. Schmidt, M.D., Chicago, Illinois; *Deep Hostility, the Nose, and Headache.*

10:00 A.M. Guest Speaker: Baynard T. Horton, M.D., Chief, Headache Clinic, Mayo Clinic; *Cough Headache; Clinical Varieties and Treatment.*

11:00 A.M. Guest Speaker: Charles I. Thomas, M.D., Professor of Ophthalmology, Western Reserve University, Cleveland, Ohio; *The Cornea.*

1:15 P.M. George R. Farrell, M.D., Rockford, Illinois; *Indications For Modern Ear Surgery.*

1:30 P.M. Chester Roc, M.D., Rockford, Illinois; *A New Surgical Approach to Entropion.*

1:45 P.M. Ray F. Beers, Jr., M.D., Rockford, Illinois; *Symptomatic Treatment for Ragweed Hay Fever.*

2:00 P.M. Guest Speaker: John W. Henderson, M.D., Chief, Eye Department, Mayo Clinic; *Proptosis Patterns.*

2:45 P.M. Guest Speaker: G. Victor Simpson, M.D., Consultant, Walter Reed Hospital; Surgeon, Washington Hospital Center; *New Thoughts on Uveitis.*

3:30 P.M. Business Meeting.

3:45 P.M. Adjournment.

Annual Clinical and Scientific Meeting of the Illinois Surgical Society

Surgical clinics conducted by the Illinois Surgical Society will be held on the 7th floor of the Cook County Hospital, Harrison and Wood Streets, Chicago, Illinois. These clinics will begin promptly at 8:00 A.M. on Monday, May 18, 1964.

The scientific meeting will be co-sponsored by the Illinois Surgical Society and the Illinois State Medical Society. Sessions of this meeting will be held at the Sherman House, Chicago, Illinois, beginning at 1:30 P.M. on Monday, May 18, 1964.

The complete clinical and scientific meeting schedules follow:

(continued on page 262)

General Assembly Speaker **Hugh H. Hussey, M.D.**

Director, Division of Scientific Activities American Medical Association

Hugh H. Hussey, M.D., Director of the AMA's Division of Scientific Activities, will deliver the general assembly address to the 1964 ISMS Convention. This talk is scheduled for Wednesday, May 20, at 2:30 P.M., in the Ball Room of the Sherman House. Dr. Hussey will discuss "**Drug Problems of the AMA.**" *Recorded below are a few preview-highlights of Dr. Hussey's address.*



The drug programs of the AMA are predicated on education of physicians, support of attitudes and activities that will speed advancement of knowledge through research, and protection of the public.

The instruments for carrying out the first mission are the Department of Drugs with its related Council on Drugs and Committee on Cutaneous Health and Cosmetics. Information to physicians is transmitted through Journal publications and the annual *New and Non-official Drugs*. The AMA, in cooperation with the U.S. Pharmacopeia Convention and the American Pharmaceutical Association, take the responsibility for determining effective non-proprietary names for new drugs. Finally, the Council on Drugs has recently enlarged its registry for Adverse Reactions. This is expected to be a clearing house for information about adverse reactions to drugs and other chemicals.

The second and third missions are facilitated through the Council on Drugs, the Council on Legislative Activities, and other resources of the AMA.

Programs related to these missions include legislative efforts whereby the AMA has repeatedly given support to laws that are designed to insure protection of the public. On the other hand, the AMA has expressed opposition to various parts of the Legislative proposal originally sponsored by Senator Kefauver. Such opposition arose from the conviction that the advancement of knowledge would be impeded. Since the passage of the Kefauver-Harris drug amendments, and the promulagation of new regulations by the FDA, the AMA has maintained an over-view of the amended law and new regulations.

In the complexities of the prevailing picture of activities under the new drug regulations, it is more important than ever that the AMA establish liaison, and maintain contact with, all interested parties—particularly the PMA, the FDA, and Congress.

It is evident that all four parties—AMA, PMA, FDA, Congress—are interested in (1) having safe, effective new drugs on the market; (2) insuring effective flow of information about the pharmacologic and therapeutic properties of drugs; and (3) detecting, evaluating, and publishing the facts about adverse reactions to drugs. A variety of motives are involved in these interests, including desire for scientific truths, protection of the public, and financial profit.

Preview of ISMS Convention Program

(continued from page 260)

Surgical Symposium—Chester C. Guy, M.D., Chairman

8:00 A.M. to 10:30 A.M.: In the Surgical Amphitheatre: *Abdominoperineal Resection For Carcinoma of the Colon.* Surgeon: Peter A. Rosi, M.D. *Discussion of Indications for Anterior Resection:* R. Kennedy Gilchrist, M.D. *Management of Perineal Recurrence:* J. C. Thomas Rogers, M.D.

11:00 A.M. to 12:00 Noon: At the Hektoen Institute: *Surgical Management of Carcinoma, Case Presentation and Discussion:* Henry T. Randall, Professor of Surgery, Columbia University Medical School; Director of Memorial Center for Cancer and Allied Diseases, Sloan-Kettering Institute for Cancer Research, New York, N.Y.

8:00 A.M. to 10:30 A.M.: In Operating Room "A." *Gastrectomy for Ulcer Diathesis.* Moderator: Frederic A. de Peyster, M.D., Surgeon: Robert J. Freeark, M.D. Discussion of *Gastric Freezing* by R. de Wall, M.D., and Foster L. McMillen, M.D.

8:00 A.M. to 10:30 A.M.: In Operating Room "B." *Surgical Management of Large Ventral Hernia of the Abdomen.* Surgeon: Manuel E. Lichtenstein, M.D. Discussion: Amos R. Koontz, M.D., Johns Hopkins Medical School, Baltimore, Md.

8:00 A.M. to 10:30 A.M.: In Operating Room "C." *Surgery For Peripheral Vascular Disease.* Moderator: Geza de Takats, M.D. Surgeon: Robert J. Baker, M.D. Discussion by Gustav W. Giebelhausen, M.D., and Jack C. Cooley, M.D.

8:00 A.M. to 10:30 A.M.: In Operating Room "D." *Radical Mastectomy For Breast Carcinoma.* Moderator: George E. Block, M.D. Surgeon: Frank A. Folk, M.D. Discussion by Eugene Lutterbeck, M.D., *Radiation for Cancer;* and Thomas W. Samuels, M.D.

8:00 A.M. to 10:30 A.M.: In Operating Room "E." *Vaginal Hysterectomy with Perineal Repair.* Surgeon: Walter J. Reich, M.D. Discussion by Mitchell Neehtow, M.D. *Management of Carcinoma of the Cervix,* Donald H. Dexter, M.D.

8:00 A.M. to 10:30 A.M.: In Operating Room "F." *Surgery For Megacolon, Nerve Biopsy.* Surgeon: John R. Raffensberger, M.D. Discussion by Orvar Swenson, M.D., and Paul F. Fox, M.D.

8:00 A.M. to 12:00 noon: In Operating Room "G." *Surgery For Intraoral Cancer.* Moderator: Kenneth Lewis, M.D. Surgeon: Orion H. Stuteville, M.D. Discussion by Robert L. Schmitz, M.D., and Henry C. Southwick, M.D.

Scientific Meeting

1:30 P.M. to 2:30 P.M.: Panel Discussion: *Surgery of the Spleen.* Moderator: Robert J. Baker, M.D. *Hematologic Disease:* Steven O. Schwartz, M.D. *Intra and Post Operative Management:* William H. Requarth, M.D. *Trauma:* Manuel E. Lichtenstein, M.D.

2:30 P.M. to 3:30 P.M.: *Endocrine Management of Breast Cancer:* E. Lee Strohl, M.D., and Henry T. Randall, M.D., Professor of Surgery at Columbia Medical School; Director of Memorial Center For Cancer and Allied Diseases, Sloan-Kettering Institute for Cancer Research, New York City.

3:30 P.M. to 4:30 P.M.: Panel Discussion: *Complications of Cholecystitis.* Moderator: Robert J. Freeark, M.D. *Pancreatitis and its Sequelae:* Charles B. Puestow, M.D. *Empyema and Hydrops:* Karl A. Meyer, M.D. *Obstruction of the Common Bile Duct:* John T. Reynolds, M.D.

All members are invited to attend.

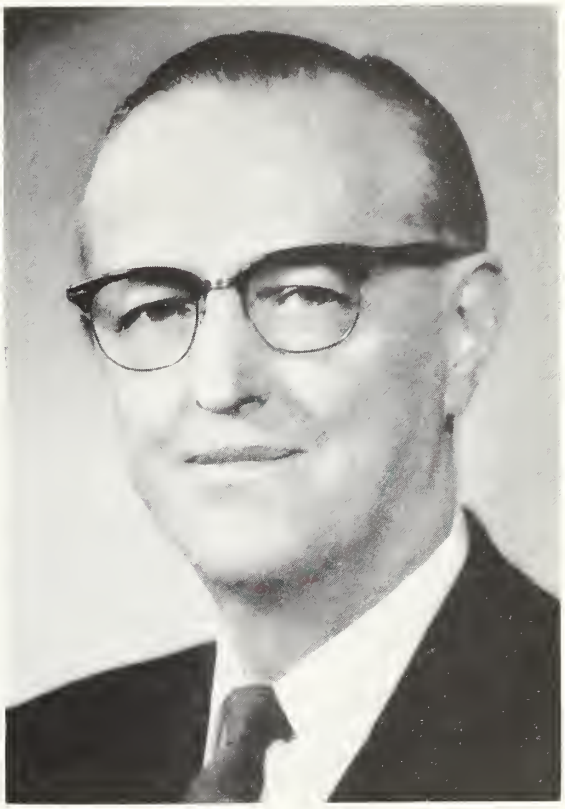
First Annual Public Affairs Dinner

Walter M. Judd, M.D.

Former Congressman, Minnesota (1942-1960)
Former U.S. Delegate to the United Nations

"Professional People

in Public Affairs"



Plans are under way to have members of the Illinois Congressional Delegation on hand to meet their physician constituents at this affair.

Monday, May 18, 1964 6:00 P.M.

Sherman House, Chicago, Illinois

This presentation is one of the special features of the new ISMS Public Affairs Program.

On January 11, 1964 the House of Delegates created a Public Affairs Committee and a Public Affairs Program.

The purposes of the Public Affairs function are to interpret the general issues, development of political awareness, and to encourage sophisticated participation in political campaigns.

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT

The Illinois Medical Assistants Association is seeking the help of ISMS members in raising the professional standards of the state's medical assistants. A unique program, instituted to give the qualified medical assistant the opportunity to pass a special board examination, is described below.

The aims of the American Association of Medical Assistants and the Illinois chapter have been lauded by both the AMA and ISMS. All Illinois physicians are urged to encourage their medical assistants to become a part of this educational organization.

A Message to the Doctor—From His Medical Assistant

How do we stand on the important issues? Here is a digest of recent I.M.A.A. activities: Miss Bettye Fisher testified before the House Ways and Means Committee against the King Bill (HR4222). Bettye was then serving as the President of the American Association of Medical Assistants. Her testimony is part of the Record.

Just recently our AAMA President, Judy Coleman, and our immediate Past President, Alice Budny, testified again before the House Ways and Means Committee against the present King-Anderson Bill (HR3920).

At the AAMA annual meeting, held in Florida in October 1963, a resolution drafted by the IMAA (our State Association) received the complete support and commendation of the Board of Trustees and House of Delegates. This resolution was a promise to assist the American Medical Association in its opposition to socialized medicine.

Many local Medical Assistant Associations have sent resolutions to their own local medical societies pledging their support in this fight.

Our national, state and local legislative committees have endeavored to educate their members on these bills on Socialized Medicine. This year, a complete analysis of the King-Anderson Bill was sent to each and every member of IMAA. Included with this analysis was a list of the House Ways and Means Committee members and the Senate Finance Committee members.

Each of our news publications (IMAA Newsletter and AAMA Bulletin) have carried articles on medical legislation.

You, as our doctor-employer, can help us. Talk with your medical assistants regarding the real and apparent danger of socialized medicine. Tell them how they can help. Answer their questions about the issues involved. If you do not know the answers, direct them to the proper sources of information, your ISMS *Journal* staff can help you in this respect.

Your medical assistants are the ones who will have to explain to your patients why only about 25 per cent of their medical bills are covered—when they thought that 100 per cent would be covered. They are the ones who will have to fill out forms for the government—they are the ones who will have to try to collect your bills from these people who are interested in getting "something for nothing."

Your medical assistants are vitally interested in preserving the integrity of medicine in the United tates. Give them the benefit of your knowledge and let them help you in this fight. They want to help, but they need your counsel.

PULSE
of the ILLINOIS STATE MEDICAL SOCIETY

A Service of the Public Relations Division *March, 1964*

ISMS Task Force Converges on Washington

In a three-day whirlwind of meetings, discussions and speeches in the nation's capital last month, a spirited ISMS delegation detailed the hopes, views and progress of Illinois physicians to top-ranking government officials.

The conference—which began February 4—was sponsored by the new Committee on Public Affairs in cooperation with the Legislative Committee.

Spearheaded by ISMS President Dr. Harlan English, the delegation attended a full schedule of discussion meetings with U. S. legislators as well as luncheon and dinner meetings featuring such distinguished speakers as Senator Barry Goldwater, Senator Hubert Humphreys and Governor Nelson Rockefeller.

At the luncheon on February 6, Governor Rockefeller charged that the nation was plagued by a "leadership gap." By this November 11, he said, the nation must decide "whether to assure leadership and initiative in the world or continue to navigate in the rough wake of a course already churned by the Soviet."



ISMS conferees with Congresswoman Charlotte T. Ried (R-15th District) of Aurora, are from left: Dr. J. A. Newkirk, Elgin, Public Affairs Committee Chairman; Dr. Richard Verbic, Elgin; and Dr. John Ovitz, Sycamore.

CONFERENCE CANDIDS



LAST MINUTE CHECK on program is made by Dr. V. P. Siegel, left, East St. Louis, before he, Mrs. Siegel and Rep. Melvin Price enter assembly hall. Dr. Siegel is Chairman of the Illinois State Medical Society's Committee on Legislative Activities, which co-sponsored the Washington Conference last month along with newly formed Public Affairs Committee.

Highlighting the conference was a reception on February 5 at which Senator Barry Goldwater was honored speaker.

Conference keynote was struck by Tuesday luncheon speaker Roger Fleming, secetary-treasurer and director of the American Farm Bureau Federation, who said: "Today more than at anytime in history it is obligatory for doctors and their wives to uphold the courage of their convictions and speak their views."



WHAT'S SENATOR GOLDWATER REALLY LIKE? ISMS Executive Administrator Robert L. Richards, left, ponders the question during brief meeting ot Public Affairs reception in Washington February 5.

"Roving Panel" To Highlight Secretaries' Conference

Should county medical societies be incorporated? How can attendance at county society meetings be improved? What is the county secretary's responsibility in grievance matters?

These are only a few of the questions to be discussed by county secretaries and a roving panel of experts at the Secretaries' Conference in Springfield April 12. Heading the panel will be ISMS Secretary-Treasurer Jacob E. Reisch, Springfield, assisted by members of the ISMS Board of Trustees and executive staff.

The Conference—sponsored to the Illinois State Medical Society—is held annually to give the secretaries of every county medical society in the state an opportunity to meet and exchange views on common problems. For the first time this year, presidents-elect of the county societies have been invited to attend and participate.

COUNTY CAPSULES

★ ★ ★

COLES-CUMBERLAND Medical Society will hear Dr. Warren C. Jenkins, Associate in Medicine at the Northwestern School of Medicine, Chicago, speak on the subject of "Metabolic Aspects of Disease" during its meeting in Mattoon April 29.

★ ★ ★

COOK COUNTY physician W. W. Bauer, Director Emeritus of Health Education of the American Medical Association, addressed the Woman's Auxiliary of the Decatur and Macon County Hospital on the occasion of its tenth anniversary March 12. Dr. Bauer is well known for his syndicated newspaper column and as moderator of the "Medically Speaking" show which appears weekly over UHF Channel 26.

★ ★ ★

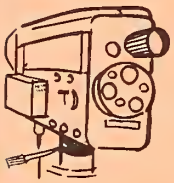
DUPAGE COUNTY Medical Society is sponsoring a essay contest for all high school students in the county. Choice of topics are "The Advantages of Private Medical Care" or the "Advantages of the American Free Enterprise System Over Communism." First prize is $150.

In a month of bustling activity, the DuPage society also met with clergymen to discuss Medicare. Chief speaker was Dr. William Perkins, county society president.

On March 22 and May 17, the society and county health department plan Sabin on Sunday programs. It will be the largest mass immunization program ever undertaken in DuPage County.

★ ★ ★

MACOUPIN COUNTY Medical Society is also reserving two Sundays, March 8 and May 3, for a county-wide program to provide Sabin oral polio vaccine.



ISMS ON THE AIR



"Plaque-ated" Radio Award Winners



Smiles were contagious at awards luncheon February 10 as President Elect Dr. E. A. Piszczek, third from left, presented ISMS radio awards to three Chicago area stations. News Director Reese Rickards of station WJJD accepted plaque for his station's presentation of "Today's Health Tip" more than 1,000 times in 1963. Award to WGN, for its continuous presentation of "Medical Interview" during 1963, was accepted by Public Affairs Director Al Field Jr., second from left. WAAF's Phil Lind, far right, was awarded plaque for being "the best medical interviewer in Chicago."

'64 Radio-TV-Press Awards Announced

Awards to acknowledge "achievments in communications contributing to a closer understanding between the medical profession and public in Illinois during 1964" will be made by the ISMS Public Relations Committee at a special dinner early next year.

The awards program—first such undertaking by the society—will present citations of merit to outstanding entries from radio, television and newspapers throughout the state.

Eligible entries will include distinguished examples of a single program, series, news story, feature editorial or continuing series explaining practical health problems; medical procedures; recent medical advances; medical legislation; economic issues; or items of historical or feature medical interest.

Award winners will be entered in the American Medical Association Journalism competition for 1964, which offers a first prize of $1,000 for winning entries in each category.

"This program, we feel, will not only reward outstanding efforts by media in behalf of health education but will stimulate future efforts in medical programming and reporting," explained PR Committee Chairman Dr. Leo P. A. Sweeney.

Need Speaker Fast? Call "Minuteman"

Illinois physicians or their wives whose organizations need a qualified speaker—even on as little as two hours' notice—are invited to get one through the Smith Kline & French Laboratories' "Minuteman" Speakers' Bureau Service.

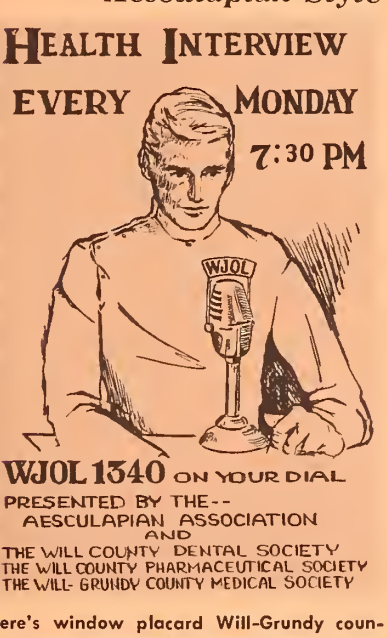
"The 'Minutemen' comprise about 100 SKF sales representatives well-trained to deliver any one of four speeches," explained SKF Community Relations Manager Robert Haakinson during a recent staff meeting at ISMS Headquarters.

Although the speeches are read, Haakinson asserted that their content is non-commercial and acceptable to almost any group interested in general subjects of medicine and health.

For more information—or a speaker in a hurry—contact:

Robert Haakinson
Smith, Kline & French Laboratories
1500 Spring Garden Street
Philadelphia 1, Pennsylvania
Locust 4-2400

"*Medical Interview*" *Aesculapian Style*



Here's window placard Will-Grundy counties' Auesculapian Association uses to promote their local "Health Interview" Series over station WJOB, Joliet. The series—featuring a local physician, dentist or pharmacist speaking on some timely health subject—is an adaptation of ISMS' "Medical Interview," broadcast on WGN in Chicago and 27 stations downstate.

Trustee Leads Governor's Tour



Wearing his "other hat" as Chairman of the Governor's Committee on Rehabilitation, ISMS Trustee Dr. Frank J. Jirka, Jr., Chicago leads Governor's tour through Rehabilitation Institute of Chicago January 17. From left are: Governor Otto Kerner; D. Elon Irish, administrative assistant for the Northwestern University Division of Prosthetic and Orthotic Education; Dr. Jirka; and Dr. Alfred Slicer, Superintendent of the Board of Vocational Education for the State of Illinois. Tour was part of inspection of rehabilitation facilities in the Chicago area.

'Bright' Boy Wins MSHT Diploma

Eleven-year-old Joseph Bright has parlayed a kidney infection and intelligence befitting his name into an early diploma.

He was among 10,000 persons enrolled in the 16-week "Medical Self-Help Training" course presented over WTTW-TV.

The Illinois State Medical Society sponsored the half-hour series of television lectures given by Dr. Max Klinghoffer.

Joseph, son of Mr. & Mrs. Victor Bright, 6255 N. Talman, is an eighth-grade student at Clinton Elementary School. His presence was conspicuous among the adults who recently took the final examination at the Ravenswood YMCA.

But Joseph says he didn't mind the competition. In fact, he says his more-than-academic interest in the course was an advantage.

"I've wanted to be a doctor since I had a kidney attack when I was eight," says Joseph. "I asked all the questions about it I could then and I've tried to read everything I could about medicine ever since."

Joseph presented a weekly school report on the subjects covered by Dr. Klinghoffer during the duration of the course. Among them were "Shock", "Emergency Childbirth", "Fractures", "Bleeding and Bandaging" and "Burns".

Joseph will enter Mather High School in September.

"Medical Self-Help Training" diplomas are being presented currently to those who passed the final examinations given at 13 locations in four counties.

County Society Assists Rheumatic Fever Stint

The DuPage County Medical Society is cooperating in the distribution of 85,000 leaflets alerting parents to the dangers of rheumatic fever.

The leaflets—entitled "Prevent Rheumatic Fever"—will be taken home from school by the children to remind parents that professional medical care should be sought whenever their children have a sore throat.

Distribution of the leaflets to all county elementary schools is being carried out by the Heart Council of DuPage County. In addition to the medical society, the county health department and school board are cooperating in the program.

AUXILIARY NEWS

EDITOR
Mrs. Oliver Veneklasen
ASS'T EDITOR
Mrs. Theodore Proud

Women's Viewpoint on Public Affairs



Among the St. Clair County contingent exchanging views with Rep. Melvin Price, second from left, at Public Affairs Conference in Washington last month was State President Elect Mrs. Willard Scrivner, East St. Louis. Dr. Scrivner looks on at Mrs. Scrivner's immediate right while Dr. Charles R. Frazer of East St. Louis, far left, explains view of pending legislation.

Auxiliary Lends Helping Hand



Mrs. John M. Tindal, center, state civil defense chairman, collects tests from two of more than 100 persons taking Medical Self Help Training exam at Austin Avenue YMCA last month. Exams were given for ISMS television course on emergency care, in which more than 10,000 Chicago area persons enrolled. Four other Auxiliary members "pitched in" at testing centers throughout Chicago.

Convention Tid-Bits

TUESDAY, there will be an Open House in the President's Suite followed by theatre and Dinner Party.

WEDNESDAY, a Continental Breakfast with original skit "Out at the Chimney" will be presented by Barbara Carter. Mrs. Haven Smith from the Farm Bureau will speak on "We're in This Together." Luncheon and Fashions, honoring Mrs. William H. Evans, President Elect of AMA Auxiliary, will be held at the new Continental Hotel.

THURSDAY, don't forget the Annual Dinner. If you have trouble with "Pedis Frigidis," come and witness "the cure" by Will-Grundy County Auxiliary. Finally, there will be the installation luncheon featuring Sulie Horand, musical dramatist in "Sound of Music."

'64 AMA PLANS

Pre-convention activities will begin on Saturday, June 20. Your special interest is called to the Tea and Fashion Show, honoring Mrs. C. R. Stoltz, president, and Mrs. Wm. H. Evans, president-elect, on Sunday, June 21, from 4:00 to 6:00.

A WONDERFUL Auxiliary Program For The New Year . . .



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Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

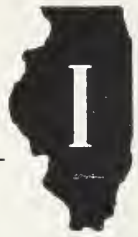
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NEWS and ANNOUNCEMENTS



State Legislature Establishes Department of Public Aid

The 1963 State Legislature established the Department of Public Aid and abolished the Illinois Public Aid Commission.

For nearly 25 years, the State Medical Society has had an Advisory Committee to the Public Aid Commission to counsel matters of administration and on standards of quality, quantity, and cost of medical care under public aid programs.

The Committee cooperates with County Medical Society Advisory Committees and serves as a financial review body. It also serves as liaison with the Department to foster good understanding and relationships.

In view of the recent legislative change, the Society was concerned whether the State and County Advisory Committees would continue to serve the Department in the same capacity. Mr. Harold Swank, Director of the Illinois Department of Public Aid, assured the Society in the following letter that he and Governor Kerner want the Committees to carry on as before.

The Illinois State Medical Society looks forward to working closely with the Department of Public Aid and offers its continued assistance to Mr. Swank and his staff in the formulation of basic policy on Illinois medical care programs for recipients of public aid.

State of Illinois
Department of Public Aid
October 18, 1963

Harlan English, M.D., President
Illinois State Medical Society
360 North Michigan Avenue
Chicago, Illinois

Dear Dr. English:

I was reminded at the meeting of the State Medical Advisory Committee to the Department of Public Aid on October 5, that I wanted to write and tell you how much we appreciated the cooperation of the State Medical Society in working with the public aid programs through the years. Governor Otto Kerner sent me a copy of your letter of July 26, 1963, in which you called his attention to the long and satisfactory relationship that has existed between the Illinois State Medical Society and the Illinois Public Aid Commission, and advised him that the Medical Society will continue to offer advisory services to the new Department of Public Aid.

I would like to thank you for your thoughtfulness in writing to Governor Kerner. I am, of course, familiar with the important role the Illinois State Medical Society has played in the formulation of basic policy for the Illinois medical care program, and I know that you have given long hours of your own personal time as a manifestation of your interest and concern in this program.

Sound and unbiased professional advice is vital for the proper management of the medical program for public assistance recipients. The experience, knowledge and recommendations of the State Medical Advisory Committee and the County Medical Advisory Committees will be needed for the solution of the medical care problems that arise in the administration of the medical program.

The Department of Public Aid will need the counsel and guidance of the State Medical Society and you can be assured that Governor Kerner and I will want the close relationship that has existed to continue.

Sincerely yours,

Harold O. Swank, Director

Appointments

New Associate Dean at Northwestern

Dr. Joseph A. Wells has been appointed associate dean of Northwestern University's Medical School.

He succeeds Dr. John A. D. Cooper who is now Dean of Sciences at Northwestern.

In announcing the appointment, Dr. Richard H. Young, Dean of the Medical School, said Dr. Wells also will continue to be chairman of the Medical School's department of pharmacology, a post he has held since 1960. In addition, Dr. Wells will continue as chairman of the Medical School's Educational Policy Committee.

Dr. Wells, 47, received his Bachelor of Medicine, M.D. and Ph.D. degrees from Northwestern. He joined Northwestern's Medical School faculty in 1938 and became professor of pharmacology in 1950. His first scientific papers were published in 1939, and he has since authored or co-authored more than 50 such works for medical journals.

Dr. Wells currently serves as treasurer of the Illinois Society for Medical Research. He is past president of the Illinois section of the Society for Experimental Biology and Medicine. A member of the Institute of Medicine, Sigma Xi medical fraternity and the American Association for the Advancement of Science, Dr. Wells also is past associate editor of the American Society for Pharmacology and Experimental Therapeutics.

New Associate Dean at U of C

Dr. Robert Griffith Page, cardiologist and medical educator at The University of Chicago, has been appointed an Associate Dean of the Division of the Biological Sciences of the University.

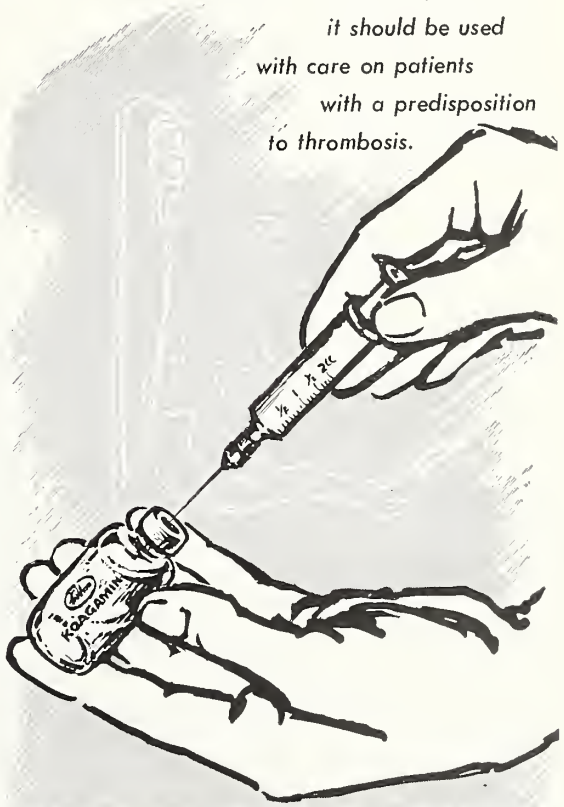
The appointment was announced by Edward H. Levi, Provost of the University.

Dr. Page will work with Dr. H. Stanley Bennett, Dean of the Division, on planning for the development and growth of program and facilities in one of the world's major centers for

(Continued on page 288)

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(Continued from page 287)

medical and biological research, teaching, and patient care.

A member of the University medical faculty since 1953, Dr. Page is known for his work both in medical education and in the study and treatment of heart disease.

He is an Associate Professor in the Department of Medicine of the University and for the past six years has also been Assistant Dean for Medical Education in the Division of the Biological Sciences.

In his new post, he will continue his interest in medical education, but his major assignment will be in the field of planning and development and public relations for the Division.

New Assistant Dean at Chicago Med.

Dr. Jules Leonard Whitehill has been appointed assistant dean of The Chicago Medical School and medical director of Mount Sinai Hospital. Announcement of these appointments was made jointly by Dr. John J. Sheinin, president of The Chicago Medical School, and Raymond L. Rusnak, president of Mount Sinai Hospital.

Announcement was further made of Dr. Whitehill's appointment as associate professor of surgery on the faculty of The Chicago Medical School, director of medical education at Mount Sinai Hospital, and attending in the department of surgery at the hospital.

Dr. Whitehill is a native of New York City. He was graduated from the College of the City of New York in 1931 and received his medical degree from New York University College of Medicine in 1935. He interned and served his residency at Mount Sinai Hospital in New York City and was a research fellow there in experimental surgery in 1940 and 1941. Following four years of service in North Africa, Italy and France with the U.S. Army, Dr. Whitehill became an attending physician on the surgical staff of Mount Sinai, Sydenham and Harlem Hospitals in New York City. He entered private practice in Tucson, Arizona, in 1948.

Recent reports suggest...insulin and sulfonylureas may accelerate lipogenesis,[1-5]...serum "insulin" levels are often elevated in obese diabetics[2,3,6]...DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.[1,3,7-9]

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Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

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Awards

Dr. Roland Pritikin Honored

Dr. Roland I. Pritikin, Chairman of the EENT Section of ISMS, was declared a graduate, and awarded the diploma of the United States Army Command and General Staff College. Dr. Pritikin holds a commission of colonel in the Medical Corps, U.S. Army Reserve.

Ob-Gyn Prizes Offered

The Central Association of Obstetricians and Gynecologists offers annual awards, totalling $750.00 for outstanding investigative or clinical work in the field of Obstetrics and Gynecology.

Papers must be written expressly for this competition, and they must be original, not having been previously presented or published.

Manuscripts, in triplicate, must be submitted to the Secretary not later than June 12, 1964. The author's identity shall not show on an of the three copies, the only identification being a covering letter and an abstract not to exceed 150 words. The abstract should show the authors as they would appear on the published paper.

The Annual Prize Award of $500.00 and a Certificate of Merit Award of $250.00 will be presented to the two successful authors at the annual meeting of the Association. These papers shall be presented by the essayists, as part of the Scientific Program, at the annual meeting September 24-26, 1964 at Milwaukee, Wisconsin. The papers will be offered for publication to the American Journal of Obstetrics and Gynecology with the scientific proceedings of the Association. For further details, write the Secretary, Thomas W. McElin, M.D., 636 Church Street, Evanston, Illinois 60201.

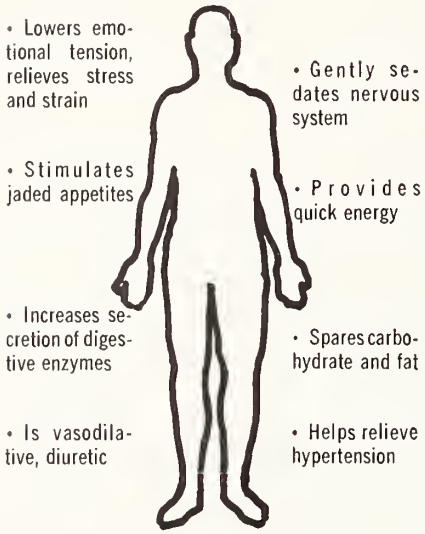
Among those eligible to compete are accredited physicians, teachers, research workers and medical students living within the geographic area of the association. This area includes the state of Illinois.





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Local Physicians Honored By American College of Physicians

Thirty-two Illinois physicians have been honored by the American College of Physicians—an international organization representing 12,300 specialists in internal medicine and related fields.

Dr. Wesley W. Spink, Minneapolis, Minn., President of the internists' group, announced that the following physicians from the state were among those designated as Fellows and Associates of the American College of Physicians:

Elected as Fellows were: Drs. Michael M. DiGilio, Paul B. Glickman, Robert R. J. Hilker, Benjamin M. Kaplan, George Kroll, Stanley L. Leithold, and Milton M. Mosko, all of Chicago; Dr. Charles G. Farnum, of Peoria; Dr. Robert C. Murphy, of Quincy; Drs. Morton A. Goldman and Irving Greenspan, both of Skokie; and Dr. Earl R. Ensrud, of Urbana.

Selected as Associates were: Dr. Fred L. Jones, Jr., of Belleville; Drs. Maurice M. Albala, Antonio J. Carballo, William B. Furgerson, Jr., Robert N. Hedges, Jr., Edsel K. Hudson, Patricia A. McCreary, Charles P. Nadler, Jerome E. Neustadt, Leonard S. Sluzynski, and Julian I. Zinder, all of Chicago; Dr. Stuart K. Olson, of DeKalb; Dr. Theodore L. Bryan, of East St. Louis; Dr. Morton D. Willcutts, Jr., of Galesburg; Dr. Randall L. Mann, of Kankakee; Dr. Benjamin J. Massouda, of McHenry; Dr. Edwin R. Priest, of Park Ridge; Dr. Bruce W. Johnson, of Quincy; and Drs. Charles L. Picus and Harold E. Zenisek, both of Rockford.

Meetings

AMA Congress on Environmental Health

The problems of health and environment have been attacked piecemeal on many fronts. This year they will be brought together and attacked as a whole.

The American Medical Association will sponsor the AMA Congress on Environmental Health Problems May 1-2 in Chicago (Sheraton-Chicago Hotel).

(Continued on next page)

(Continued from page 290)

Theme of the Congress is a question:

"Can Some Diseases Be 'Engineered' Out of the Environment?"

The Congress will center on four major areas of environment that have been related to health —air pollution, water pollution, pesticides and radiation.

The AMA is a medical organization, and thus the Congress will aim its program content directly toward the physician in practice, centering on the relation of environmental health problems to medical practice and role of the physician in evaluation and prevention.

50th Annual Advocacy Institute

Nationally prominent physicians and lawyers will lecture on and demonstrate Medical Malpractice litigation at the Fifteenth Annual Advocacy Institute, March 20-21, on the University of Michigan campus. The high-level program will be presented by the Institute of Continuing Legal Education of the University of Michigan Law School—Wayne State University Law School and the State Bar of Michigan.

Physicians attending the program will learn how to assist their lawyers in preventing unwarranted malpractice suits and how to help assure fair recovery for patients with justifiable grievances.

William J. Curran, Director of Boston University's Law-Medicine Research Institute and a Lecturer in Legal Medicine at Harvard Law School, will open the two-day seminar by lecturing on Problems of Establishing a Standard of Care.

Professor Marcus L. Plant of the U-M Law School will discuss Informed Consent—A New Area of Malpractice Liability. Sol Schreiber, Co-attorney of Record and Trial Counsel of the Brooklyn Office of Liberty Mutual Insurance Company will cover Res Ipsa Loquitur and Other Special Problems of Proof.

Obtaining Medical Experts (A Crisis in Interprofessional Cooperation) will be dealt with by two lecturers. Dr. Charles G. Child, III, Professor of Surgery and Chairman, Department of Surgery, the U-M Medical School, will speak on Lawyers, Doctors and Medical Mal-

(Continued on page 292)

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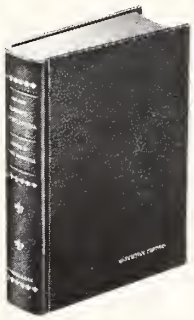
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(Continued from page 291)

practice: A Surgeon Reacts. Professor David W. Louisell of the University of California Law School (Berkeley) will lecture on Lawyers, Doctors and Medical Malpractice: A Legal Viewpoint.

At a special evening session on Friday, March 20, Bernard D. Hirsh, Director of the American Medical Association's Law Department, will speak on Medical Malpractice from the standpoint of the American Medical Association.

Dr. Andrew S. Watson of the U-M Law and Medical faculties will lecture on Handling the Emotional Factors Involved in a Medical Malpractice Action.

In addition to hearing the lectures, registrants will watch two realistic demonstrations of malpractice litigation. In one hypothetical case, an orthopedic surgeon is on trial for malpractice arising out of his alleged negligence. Associate Justice Theodore Souris of the Michigan Supreme Court will preside.

In the other case, a general practitioner and a hospital are being sued for malpractice arising out of the alleged negligence of both the hospital and the physician. Judge Victor J. Baum of the Wayne County Circuit Court will preside.

Top trial lawyers from around the nation will take hypothetical parties and witnesses on direct and cross-examination to demonstrate courtroom technique in medical malpractice actions. These advocates will also deliver closing arguments.

Lawyers participating in the demonstration will be: John Alan Appleman, Urbana Illinois; William Colson, Miami; Jacob D. Fuchsberg, New York; R. Crawford Morris, Cleveland; Charles M. Rush, Chicago; and Murray Sams, Jr., Miami.

Narrator for all sessions, including the evaluation panels, will be Professor John W. Reed of the U-M Law School, who is currently a Visiting Professor at Yale Law School.

Portraying parties and witnesses at the hypothetical demonstrations will be: Dr. Carl F. Metten, Senior Clinical Instructor in the orthopedic Surgery Section, the U-M Medical School; Miss LaVerne Sommers, R.N., Clinic Nurse, the U-M Hospital; Dr. John T. Hayes, Associate Professor of Surgery, the U-M Medical School; Dr. Gerald L. Brody, Assistant Professor of

(Continued on next page)

(Continued from page 292)

Pathology, the U-M Medical School, and Mr. and Mrs. Theodore Heusel, professional actor and actress, Ann Arbor.

Cooperating in the presentation of this interprofessional program is the Medicolegal Problems Committee of the State Bar of Michigan.

Fee for the program is $30. This includes all the lectures, demonstrations and panel discussions plus two reference books. Checks should be made payable to the Institute of Continuing Legal Education and mailed to: E. Donald Shapiro, Director, Institute of Continuing Legal Education, Hutchins Hall, Ann Arbor Michigan.

Michael Reese Alumni To Meet

The annual reunion of the Michael Reese Hospital Staff Alumni Association will be held on Wednesday, May 27, 1964. The program will include morning clinics and lunch at the Michael Reese Hospital and Medical Center. A banquet will be held at 6:30 P.M. that evening at the Furniture Club.

Former house staff and present attending staff members are urged to make reservations at once to: Michael Reese Hospital Alumni Association, 29th and Ellis Avenue, Chicago 16, Ill.

Radiation Exposure Records to be Registered

A central registry for the recording of radiation exposure records of persons working with radiation sources is being established in the Illinois Department of Public Health, Dr. Franklin D. Yoder, director of Public Health, said today.

The department also is initiating activities to evaluate and approve all firms which supply film badge monitoring service in Illinois. These new activities are in accordance with legislation enacted by the 73rd General Assembly, based upon recommendations of the Illinois Legislative Commission on Atomic Energy.

(Continued on page 294)

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(Continued from page 293)

The department is revising its regulations to specify the types of individuals which it will require to be monitored for radiation exposure and will notify each employer of his responsibility for reporting radiation exposure records under this law.

The governor of Illinois now is authorized to enter into an agreement with the U.S. Atomic Energy Commission providing for the State of Illinois to assume certain of the regulatory functions of the federal government in accordance with amendments to the Illinois Radiation Protection Act. These functions include the licensing of certain radioactive materials commonly used for peace time purposes. The department currently is working closely with representatives of the Atomic Energy Commission to assure that regulations of the state are compatible with those of the federal government in preparation for an agreement.

Authority has been placed in the department to acquire and operate a site for the concentration and storage of radioactive waste materials. This is scheduled for future development.

The department has nearly completed its initial inspection of 7,500 registered radiation installations in Illinois. These include medical, dental, veterinary, industrial, educational and research establishments that use one or more kinds of x-ray machines or radioactive materials. All medical radium sources registered with the department have been inspected and checked for leakage. In a few instances some radium sources had lost their integrity and contaminated the offices in which they were used. These premises have been decontaminated to safe levels, as established by department standards. Damaged sources are returned to the supplier for repair.

In one instance, a damaged source was noted in the safe deposit box of a deceased physician. Department personnel were instrumental in arranging for the effective removal of the contamination found in the box and its vault.

One of the larger industries in Illinois is completing installation of a 24 million electron volt betatron, which it will use to radiograph heavy steel castings. The shielding required to reduce radiation to acceptable levels in surrounding

(Continued on page 297)

(Continued from page 293)

areas will be a minimum of nine feet of sand and concrete. This is the second betatron installed in the plant site.

In cooperation with the Illinois State Medical Society, the department has made available to all hospitals a copy of "Administrative Procedures and Regulations for Users of Radioactive Isotopes." This action is expected to assist the hospital in maintaining control over its radioactive materials and in complying with the department regulations.

Radioactivity in the atmosphere is monitored at Springfield, Metropolis and Channahon on a 24-hour basis to provide current estimates of the level of fallout from weapons testing programs. Rivers and streams throughout the state are checked for radioactivity at regular intervals.

Hospital Report

Patients usually want to know more about their ills and treatment than doctors or nurses are willing to divulge, a study sponsored by the National Institutes of Health indicates.

The study, published in the current issue of HOSPITALS, Journal of the American Hospital Association, was conducted by Joan S. Dodge, Ph.D., Cornell University social psychologist.

"The doctor won't take time to explain things to me," is one of the most frequent complaints of a patient, Dr. Dodge discovered. Patients interviewed in the study consistently attributed more importance to receiving information about their care than did the doctors.

"This creates somewhat of a dilemma for doctors and nurses who attempt to give specific responses to their patients," Dr. Dodge believes. "Lack of information when the patient wants it may increase his anxieties, make him less satisfied with his care, or make him dislike his doctor and nurses."

Too much information to the patient may have the same effect, however, the psychologist notes. "Giving total patient care implies the satisfaction of psychological as well as physiological needs," Dr. Dodge writes. "Not the least of these is the patient's need to know."

Failure to satisfy the wish for information

(Continued on page 298)

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(Continued from page 297)

may create a state of mind in the patient that could seriously interfere with the patient's ability to handle the stresses created by his illness, Dr. Dodge believes.

She suggests reasons why physicians consider it unimportant or inadvisable to give information to patients. One is because physicians believe the patient would not understand the medical treatment or diagnosis anyway.

Patient Wants Information

"A patient may ask for more information than he can absorb," Dr. Dodge says. "Another may not be able to understand what he needs to understand in order to cooperate in his own case."

In addition, a doctor must be fairly certain of his diagnosis, treatment, and prognosis before he imparts information to the patient, the study indicates. The possibility of a patient losing confidence in his doctor of bringing suit against him if the doctor is in error makes the doctor justifiably cautious in giving out information, Dr. Dodge adds.

One of the few kinds of information doctors in the study usually favored is an explanation by a nurse of what she is dong for the patient at the time she is caring for him. But a nurse should never tell the patient the kind of medicine he is being given, the doctors asserted.

Nurses questioned in the study generally believed a doctor should tell a patient if an illness is fatal or what the patient can expect in the course of his illness. However, doctors attached less importance to information of this nature.

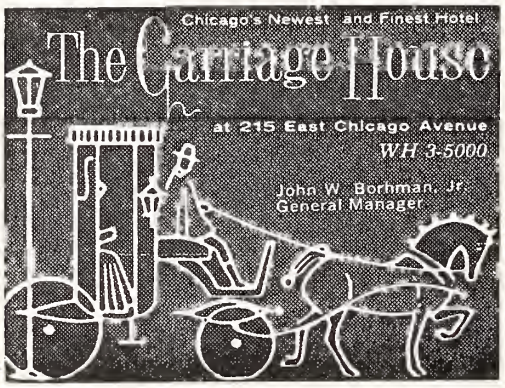
Dr. Dodge urges better communication between medical staff and patient, in order to make the patient's hospital stay more satisfying. The patient should understand why his doctor is reluctant to give some information and doctors and nurses should have a clear understanding of how much information they can safely give out, she asserts.

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McHenry and Lake Counties: Island Lake; population 1300. No resident physician. Nearest physicians at Wauconda and McHenry, Illinois, nine miles. 4 physicians within 10 miles. Nearest hospital at Woodstock, 40 miles. Citizenship required for staff membership. Nearest city, Barrington, 12 miles. Ambulance service provided by local funeral home. Housing available. Office available; 4 rooms; $175 monthly rental.

McLean County: Ellsworth; population 250; estimated population of trade area: 2,000. Nearest physicians at Bloomington, LeRoy, and Saybrook, 18, 9 and 10 miles. Nearest hospitals at Bloomington and Normal. Mennonite Hospital, 110 beds and 25 bassinets, St. Joseph's Hospital, 150 beds and 25 bassinets, Brokaw Hospital, Normal, 150 beds. Population of Bloomington, 35,000. Agricultural community.

Mercer County: Sherrard; population 600. Only physician retired several years ago. Nearest physicians at Rock Island and Moline, 18 miles, and Aledo, 21 miles. Mercer County Hospital, Aledo; 57 beds, Hill Burton; citizenship required for staff membership. St. Anthony's Hospital, Rock Island, 185 beds, Moline Public Hospital, 192 beds, Lutheran Hospital, Moline, 135 beds. 18 miles to tri-cities—Rock Island, Moline, East Moline and Davenport, Iowa. Living quarters and office space available. Financial assistance could probably be arranged if desired. Agricultural community.

Montgomery County: Fillmore 472. Nearest physicians at Ramsey, 12 miles, and Hillsboro, Vandalia and Nokomis, 14 miles. Nearest hospitals at Vandalia, Fayette County Hospital and Hillsboro, Hillsboro Hospital; 86 and 46 beds respectively. Citizenship required for staff membership. Nearest large city, St. Louis, 88 miles. Office space and living quarters available. Financial assistance would be provided if desired. Agricultural community.

Ogle County: Chana; population 300; estimated population of trade area, 2500. Several small towns in surrounding area without physicians. Only physician died February 1959, after practicing here for 43 years. Nearest physicians and hospitals at Oregon, 7 miles. Nearest large city, Rockford, 30 miles; population 105,000. Nearest ambulance service at Oregon. Combined office and home of deceased physician for sale. Office: 4 rooms with outside entrance. Equipment for sale. Modern 1½ story bungalow; 6 rooms; full basement; oil heat. Agricultural community.

Piatt County: Monticello: population 3400. Three physicians; need for a fourth. John and Mary E. Kirby hospital located here. 19 miles from Champaign; population 77,000. 2 prescription drug stores. Office space available—new office, central air conditioning, ground floor, designed for physician by architect. Agricultural area; some industry.

Putnam County: Hennepin; population 312; population of trade area: 1500. Office space available. Part time physician at Granville. Full time physician at Granville died in 1961. Local drug store with registered pharmacist. Nearest hospitals at Princeton, 12 miles, and Spring Valley, 8 miles. Available housing. Agricultural community.

Randolph County: Steeleville; population 1600. Several small towns in trade area without physicians. One physician, age 38; need for a second. Nearest hospitals at Sparta, 12 miles, Chester, 12 miles, and Red Bud, 30 miles. Nearest large city, St. Louis, 65 miles. Two prescription drug stores. Ambulance service provided by local funeral home. Office space and housing available. Office equipment available if desired. Financial assistance could be arranged.

Richland County: Noble; population 800; estimated population of trade area, 2000. Adequate office space available. Nearest hospital at Olney, 8 miles. 112 beds. Nearest physician 7 miles. Several new homes for sale. Sources of income: oil and agriculture.

Shelby County: Herrick; population 650. Nearest physician at Cowden, 9 miles. Nearest additional physicians at Pana and Shelbyville, 20 and 23 miles. Town without a resident physician for many years. Nearest hospitals at Pana, Shelbyville, Effingham, and Vandalia. Nearest city, Decatur, population 80,000; 52 miles. No local drug stores. Ambulance service provided by local funeral home. FREE OFFICE SPACE. Financial assistance could be arranged by Lions Club of Herrick. Agricultural area.

Vermilion County: Georgetown; population 3500. Three physicians including Dr. E. G. Andracki, who desires to find a replacement so that he may enter residency training. Several small towns in trade area without physicians. Nearest hospitals (2) at Danville, 10 miles; population 45,000. 2 local prescription drug stores. Ambulance service provided by local funeral homes. Office facilities: air conditioned office, waiting room, 2 examining rooms, treatment room, physician's office, laboratory, nurse's office and business office. Doctor Andracki willing to sell his office equipment; would negotiate sale on terms easiest for replacing M.D. Sources of income: agriculture and industry.

Wayne County: Fairfield; population 6400. Six practicing physicians, ages 58, 56, 44, 43, 43, and 37. Fairfield Memorial Hospital located here; 94 beds; open staff; citizenship not required for staff membership. Nearest large city, Evansville, Indiana. 70 miles. Two prescription drug stores. Ambulance service provided by local funeral home. Office facilities: four ground floor locations suitable for physician's office. Sources of income—agriculture, oil and manufacturing. Opening for two physicians: general practitioners, or internist, pediatrician or EENT specialist.

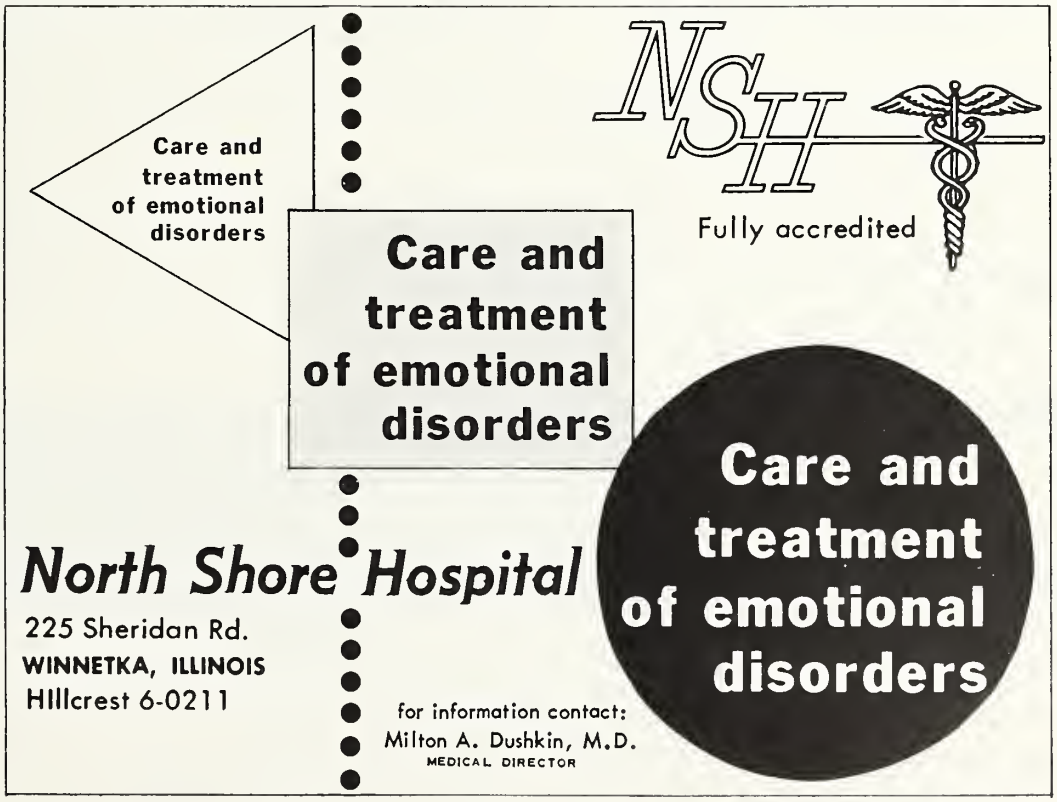
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Obituaries

William J. Brown*, Chicago, died December 23, aged 68. He was a graduate of Rush Medical College in 1922.

Benjamin J. Greenburg, Chicago, died December 14, aged 62. He was a graduate of Loyola University School of Medicine in 1930.

Joseph A. Grendeske*, Chicago, died December 15, aged 71. In 1919 he was a graduate of the University of Louisville School of Medicine and he specialized in Obstetrics and Cynecology.

Frank L. Heek*, Skokie, died December 5, aged 74. In 1919 he was a graduate of Rush Medical College.

Edward F. Kotweshall, Celeveland, formerly of Chicago, was a graduate of Rush Medical College in 1926 and was associated with St. John Hospital and St. Alexis Hospital where he died October 12, aged 63.

Gwyn H. Lile*, LaCrange Park, died January 27, aged 35. He was a graduate of Harvard Medical School in 1954 and a specialist in psychiatry. He was chief of services in the University of Chicago ward at the Illinois State Psychiatric Institute and assistant professor of clinical psychiatry at the University.

James F. Merritt*, Quincy, died January 27, aged 63. He was a graduate of the University of Illinois College of Medicine in 1931, specializing in surgery. He was a staff member of Blessing and St. Mary Hospitals, and a member of numerous medical organizations.

Halford J. Morlan, Arizona, formerly of Chicago, died February 2, aged 83. In 1905 he was a graduate of St. Louis University School of Medicine. He practiced in Chicago until his retirement in 1950.

Abraham Pathman, Chicago, was a graduate of Chicago College of Medicine and Surgery in 1916. He was a practicing physician and psychiatrist for 45 years. He died February 8, aged 73.

William E. Putz*, Arizona, formerly of Chicago, died November 8, aged 80. In 1908 he was a graduate of the Chicago College of Medicine and Surgery.

William H. Rose*, Florida, formerly of Chicago, died February 9, aged 84. He was a graduate of Bennett Medical College in 1914. He practiced medicine in Chicago for 40 years until his retirement.

Stanley J. Schriver*, Chicago, died January 20, aged 65. In 1926 he was a graduate of the University of Chicago School of Medicine and he specialized in Obstetrics and Cynecology. He was a member of the Ravenswood Hospital association.

Benedict C. Steinbreeker, Chicago, died January 13, aged 58. He was a graduate of Loyola University School of Medicine in 1931 and practiced as a general surgeon on the staff of St. Anthony de Padua and Cottlieb Memorial hospitals.

John J. Verdenius*, Chicago, a graduate of Northwestern University Medical School in 1909, died November 3, aged 83.

Louis F. Waldmann, Evanston, died January 21, aged 72. He was a graduate of the University of Illinois College of Medicine in 1918. In 1960 he retired after 30 years of practice as an E.E.N.T. specialist. He had been a staff member of Victory Memorial, St. Therese, and Lake County General hospitals.

Anna Zurko, Dixon, died January 10, aged 61. Originally from Kiev, Ukrania, she came to the United States in 1925, after graduation from Kiev Medical School. She was in charge of five cottages at Dixon State School from 1960.

**Indicates member of Illinois State Medical Society.*



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Complete psychiatric treatment in an environment for cure. A 75 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

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LEGISLATIVE LISTENING POST

April, 1964

NEW GOP HEALTH PROGRAM

A group of Republican Senators have introduced health care legislation (S-2705) as an alternative to President Johnson's Social Security Medicare Plan. Sponsored by Senator Leverett Saltonstall (R-Mass.) and five others, the Act authorizes the extension of Kerr-Mills to include an additional 12 million individuals in 32 states. Participation in the Program would include single persons with yearly income up to $3,000 and married couples with a combined income of $6,000. They would pay enrollment fees ranging from $10 annually for individuals receiving $1000 or less in income, up to $120 for those receiving $3000. Three options would be available to participants: (1) a preventive diagnostic short-term program providing 21 days of hospital services, 63 days of skilled nursing home care, surgical services and physicians services; (2) a long-term major illness program providing 120 days of hospital services plus nursing home care, drugs, laboratory services; or (3) receive a certificate to be used in defraying the premium costs of a qualified private health insurance policy. The federal government would pay 50% of the state's administrative costs and from 60% to 80% of other costs up to a maximum federal contribution of $150 for each participant. According to Senator Saltonstall, the new health care program will help persons with modest incomes who are currently ineligible for aid under the Kerr-Mills Program. The program avoids a direct means test by establishing a limit on income only. It excludes individuals fully able to meet their own medical costs. Offered as a substitute to the Johnson administration's proposal, the sponsors believe the bill will overcome the limitations of the present Kerr-Mills Act and the compulsory feature of Social Security financing under the King-Anderson Bill.

DOCTORS OPPOSE CORPORATE TAX REGULATIONS

ISMS has strongly protested proposed IRS regulations to exclude physician corporations from corporate tax advantage on March 4 in Washington, D. C. Dr. I. E. Bartlett of Wheaton and Dr. Norris Brookens of Urbana testified that the Treasury Department is exercising legislative authority in setting corporate standards. Additional opposition was generated by more than 100 witnesses including doctors, lawyers, and other professional men who

appeared in protest to the rulings; 450 others filed written objections; 82 organizations in all were represented by witnesses at the Tax Hearing. Witnesses charged IRS with deliberately defining corporations in such a way that state-sanctioned corporate group practices, such as those established under legislation passed in the last Illinois General Assembly, could not qualify. IRS rules require that corporations in general have four major characteristics: (1) continuity of life; (2) centralized management; (3) limited liability; and (4) free transferability of interests. The new regulations define these for professional corporations in such a way as to cause automatic exclusion as a group rather than on the basis of individual consideration. Before these regulations are put into effect, they must win approval of the Secretary of the Treasury.

IRS ALLOWS KEOGH FUND TRANSFERS

IRS reported unofficially that funds may be transferred from one exempt pension plan established under the Keogh law to another such pension trust without penalty. IRS indicated that it will permit this practice under Keogh law plans, but that participants transferring from one plan to another should meet two conditions: (1) there must be no curtailments of benefits as a consequence of the transfer from one exempt trust fund to another; (2) the new trust must be substituted for the old trust by amending the old plan to provide for the substitution. A physician transferring from one exempt trust to another exempt trust must complete the initial enrollment applications. The local IRS director will offer guidance in this matter.

DOCTORS' DRAFT CALL

Selective Service Boards are doing pre-inducting processing on 1,175 young physicians. The Air Force wants 650 doctors; Army 200; Navy 325. Some are needed for active duty as early as July 1, and other will be activated in August, September, and October.

ELIMINATION OF TB HEALTH GRANTS

President Johnson's proposed budget for 1965 reduces Tuberculosis Control grants from $2,900,000 to zero. Abrupt termination of these grants, without opportunity for substitute state financing, will seriously affect the Tuberculosis Control Program of the Illinois State Health Department. ISMS has recommended retention of the present program for at least another year in the following communication addressed to Illinois Senators and Congressmen:

> "The Illinois State Medical Society favors restoration of cuts in President's 1965 budget for matching funds to states for Tuberculosis Control. Complete elimination of these funds at this time, without prior planning for alternate sources of financing will adversely affect this needed program. Our action refers to the timing involved and applies to this budget only. It should not be construed as favoring the principle of Federal Health Grants or opposing overall reduction in Federal expenditures. Any possible assistance on this matter as pending before the House Appropriations Subcommittee on Labor and HEW would be appreciated."

IMJ

Illinois Medical Journal

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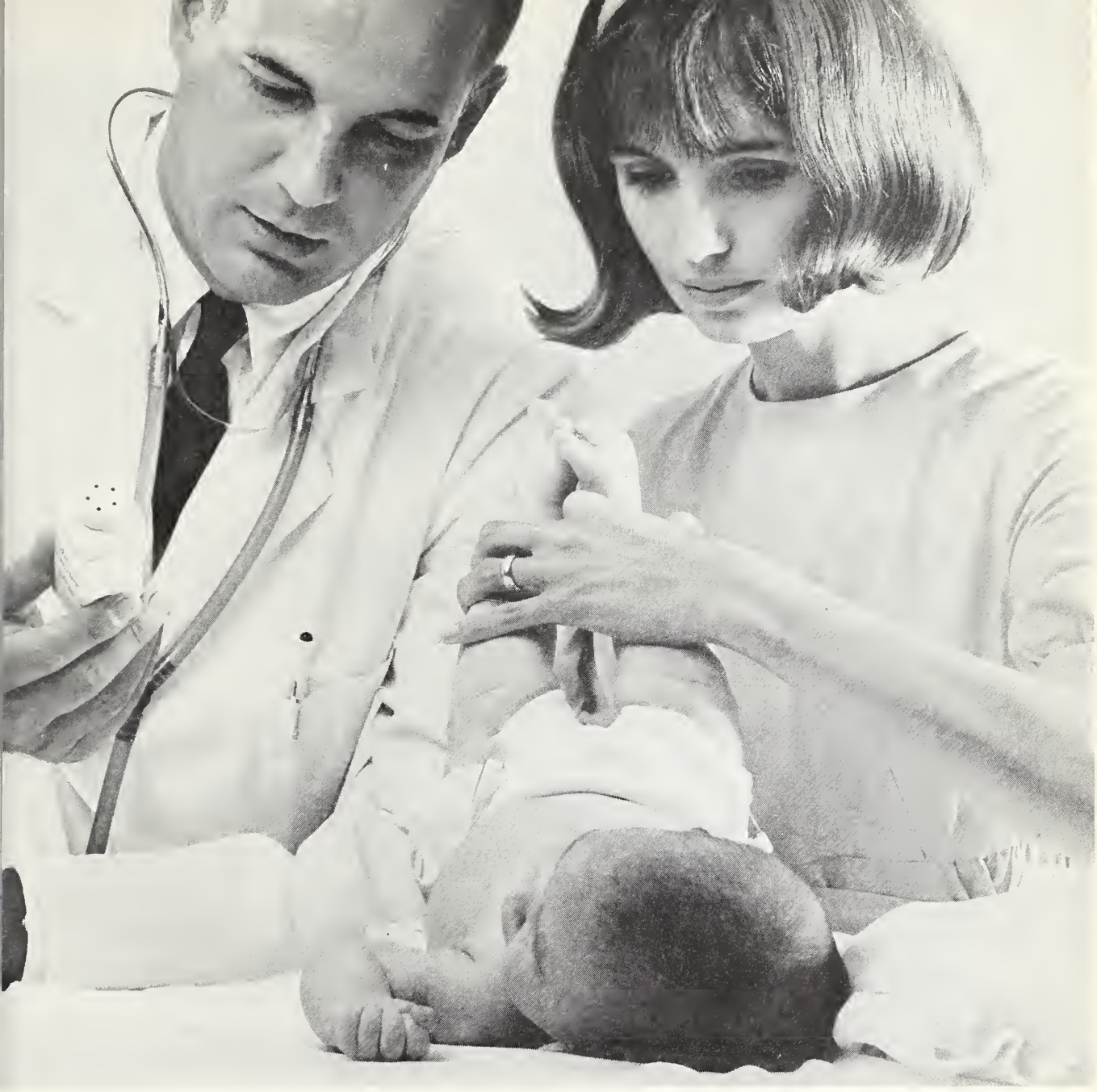
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*Donnelly, J.: A.M.A. Arch. Environmental Health, *6*: 697, June, 1963.

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New Brunswick, N. J.



AS I SEE IT FROM '360'

By Robert L. Richards
Executive Administrator

ISMS Liaison With the Medical Schools of Chicago

Chicago's five great medical schools form the nucleus of a medical teaching and research complex that is known and respected throughout the world. The Illinois physician is particularly fortunate in that he can conveniently avail himself of the numerous facilities provided by the five institutions making up this fine medical center.

ISMS, as the official organization which represents the Illinois physician, is vitally concerned with establishing and maintaining the highest possible degree of liaison with the administrators and staffs of Chicago's medical schools.

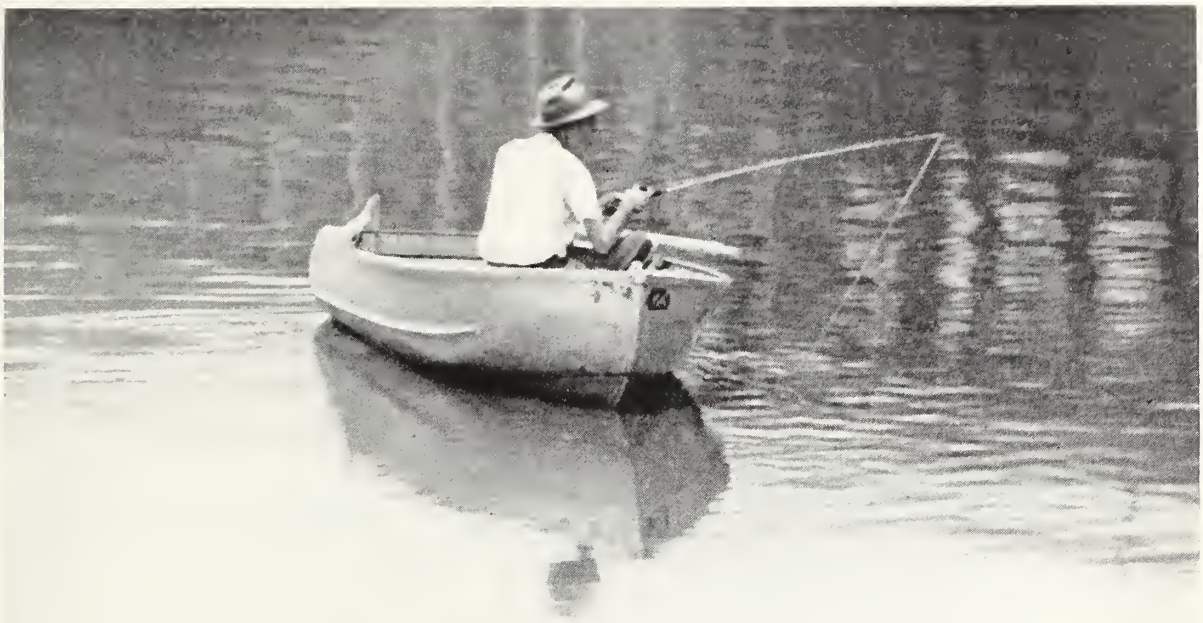
This does not mean, however, that ISMS does not already enjoy excellent rapport with these institutions. As a matter of fact, the postgraduate educational programs designed for presentation at county medical society conclaves are implemented by medical school staff members. At this time, ISMS is seeking new ways in which the Society and the medical schools can mutually benefit one another. To facilitate this end, a meeting of the medical school deans and the ISMS executive committee was convened on March 13, 1964.

As I see it, our meeting with the deans produced several particularly significant highlights. For example, Dr. John F. Sheehan, dean of the Stritch School of Medicine, suggested that all postgraduate educational programs conducted in Illinois be co-ordinated by ISMS. Such a suggestion of course enhances the prestige of a Society such as ours.

All five deans favored having medical school faculty members serve on ISMS committees. They also endorsed the idea of making ISMS membership desirable to men serving on medical school faculties. In order to stimulate such interest, the CMS recently reduced dues for all full-time faculty members who earn less than $12,000 per year.

It was felt, by all parties present at the meeting, that senior medical students, internes, and residents should be encouraged to attend ISMS conventions and meetings. The deans agreed to help stimulate the interest of such young doctors in potential ISMS membership.

When this fruitful meeting ended, I was personally assured by all of the deans that ISMS had only to contact them, and they would see to it that ISMS programs and ideas would be properly exposed to medical school staff members. The deans were unanimous in stating that meetings such as this should become official annual affairs.



The discharged mental patient . . . and Thorazine®

brand of chlorpromazine

"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. *27*:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

Brief Summary: Thorazine (chlorpromazine, SK&F) has been successfully used for 10 years in the treatment of mental and emotional disturbances, and has proven highly effective in the maintenance therapy of former hospitalized mental patients. *Principal side effects:* The most frequently encountered side effect is transitory drowsiness. Other occasional side effects include: dry mouth, nasal congestion, constipation, miosis, dermatological reactions, photosensitivity, jaundice, hypotension, increased appetite and weight; very rarely, mydriasis, agranulocytosis, extrapyramidal symptoms. *Contraindications:* Comatose states or in the presence of excessive amounts of C.N.S. depressants.

For complete prescribing information, please see *PDR* or available literature.

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Abstracts of Board Actions

Meeting of March 14-15, 1964

STATUS OF CIGARETTE ADS IN JOURNAL

The question of accepting cigarette advertisements was discussed by members of the Journal committee. Because there are existing contracts for 1964, the committee recommended that IMJ continue on the existing basis for the remainder of the year.

OPERATION "HOMETOWN"

"Operation Hometown" is now established on a branch basis in Cook County. Letters over the physicians' signatures are going out at a good rate.

FINANCE COMMITTEE

Major medical coverage has been provided for all ISMS employees. Coverage of employees' dependents is provided by means of payroll deduction.

DELEGATES TO US CHAMBER OF COMMERCE

The following members were approved as delegates to the Washington, D.C., meeting of the U.S. Chamber of Commerce: Newton DuPuy, Harlan English, Jacob E. Reisch, George F. Lull, John A. Newkirk, Philip G. Thomsen, V. P. Siegal, Frank J. Jirka, Jr., J. Ernest Breed, A. E. Steer (and staff), Robert L. Richards, Roger N. White, Harold Widmer.

MEETING WITH MEDICAL SCHOOL DEANS

Dr. English reported on the meeting with the deans of the five Chicago medical schools held at the Knickerbocker Hotel on Friday, March 13. Dr. English described an excellent rapport and a free and open discussion. ISMS officers and the deans were unamimous in their resolution that such meetings should be held once a year as a matter of policy.

REPORT OF EXECUTIVE ADMINISTRATOR

Mr. Robert Richards, ISMS executive administrator, called attention of the Board to the seven resolutions received by the House of Delegates. He reiterated his assurance that background information about any ISMS phase of operation will be made available to the reference committee by ISMS staff members whenever such information is desired or required.

DEPARTMENT OF REGISTRATION AND EDUCATION

On February 11, a meeting was held with Mr. W. Sylvester White, Director of the Department of Registration and Education. He has pledged better enforcement of the various licensing acts under the jurisdiction of the Code of his Department. His five-point program of enforcement includes:

(1) A survey of hospitals in which physicians practice without a license; (2) More frequent visits to individual doctors' offices to check credentials—especially in the case of chiropractors; (3) Continuation of educational programs in preparation for licensing examinations in the case of chiropractors not yet licensed; (4) Continued prosecution of the 40 cases filed against violators of the Chiropractic Act which are still on the books; and (5) Careful check on chiropractors who have taken the licensing examinations but who have failed. Significantly, a number of such failures continue to practice.

PUBLIC AFFAIRS

Mr. White reported that the Committee on Public Affairs has been appointed, has met, and has its various activities under way. It is hoped that each county medical society will also appoint such a committee to work in cooperation with the state society committee.

PUBLIC RELATIONS

A new 30-minute weekly public service TV program is being planned for presentation on station WCIU, Chicago's new UHF station. The program, which will be called "Medically Speaking," will be a panel show featuring Dr. W. W. Bauer. Also in the planning stage is a proposed 30-minute TV program dealing with medicine and religion. The program is to be taped in Peoria. It will utilize Peoria clergymen and physicians, and will serve as a pilot film for distribution by the AMA throughout the country.

KERR-MILLS PAMPHLETS

The February issue of IMJ carried an article dealing with Kerr-Mills. Additional copies are available. Some 350 will be distributed to all hospitals in Illinois. An additional outline of how Kerr-Mills operates has been prepared for distribution to the general public in physicians offices.

LEGISLATION

The annual public affairs conference was held in Washington in February. The follow-up conference with selected Congressmen was to take place in March. The purpose of the March meeting was to discuss legislative and public affairs problems with members of Congress personally.

HOSPITAL ACCREDITATION

Twenty eight hospitals were unaccredited as of January 1, 1963. Of these, ten have since been accredited. Four are awaiting Joint Commission survey. Four more will apply for proper accreditation after building programs are completed. Ten others have failed to qualify or to apply for a survey. The names of these latter hospitals are on file at ISMS.

NEW ASSISTANT DIRECTOR OF PUBLIC HEALTH

Dr. Edward Press was recently appointed as Assistant Director of the Illinois State Department of Public Health. Dr. Press represented Department Director Dr. Frank Yoder at the Board meeting.

MEASLES VACCINE

The Committee on Child Health has previously approved both the live and inactivated measles vaccines. It is now on record as being in favor of the immunization of children susceptible to measles. The committee's attentions are being directed toward finding means of providing vaccine to children whose families are unable to purchase the vaccine.

"DR SIMS"

The Public Relations Committee has long been concerned about an apparent lack of a strong "identification symbol" for ISMS. The committee created an animated character named "Dr. Sims"—a play on the initials "ISMS." Dr. Sims will appear on radio and TV stations every day.

DISASTER MEDICAL CARE

Some 10,000 registered for the Medical Self Help Program offered by ISMS on TV station WTTW. An estimated one half million persons viewed the programs. More than 1,000 took the final examinations, and 925 passed.

LIAISON WITH THE PHARMACEUTICAL ASSOCIATION

Four meetings have been held with representatives of the Illinois Pharmaceutical Association. Among the subjects discussed were those dealing with the relationships between medicine and pharmacy, ethics and law, the economics of medical care, and the establishment of interprofessionalism. A copy of the proposed Code of Interprofessional Relations was distributed to each member of the Board.



"Leakers" are ampoules with minute imperfections in the seal. You can't readily see the flaw, and often it's so small that liquids won't even drip through; but microscopic contaminants can slip in to render the contents nonsterile and potentially dangerous. ▪ Detecting "leakers" is the job of the vat and the blue dye. ▪ Sealed Lilly ampoules are placed in baskets, submerged in a vat containing methylene blue, and subjected to a vacuum. If there is an imperfect ampoule in the lot, the liquid is forced out. When the vacuum is released, the blue dye rushes in. ▪ With dye as the spy, elusive "leakers" are quickly spotted and rejected . . . another of the many controls that add immeasurably to the quality of the finished product.

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Lucanthone Hydrochloride Treatment of Schistosoma Infection

Caroll Birch, M.D., Basil Anast, M.D.,
Alan J. Camin, M.D., and Ira M. Rosenthal, M.D.

The number of S. *mansoni-caused* schistosomiasis cases now being encountered in many hospitals of our metropolitan areas is increasing. Significantly, this rise in the incidence of schistosomiasis has coincided with the migration of large numbers of persons from Puerto Rico to the continental United States. Although far advanced disease has been found in some patients, most of the cases have either been asymptomatic or have had subjective complaints—such as abdominal pain. This kind of complaint is, of course, difficult to evaluate.

The percentage of schistosomiasis-infected patients in a nonendemic area who develop progressive liver disease is not known. Since the schistosomes remain alive for long periods, it is likely that some of these patients develop progressive liver disease.

Treatment

Tartar emetic (antimony and potassium tartrate) has been used in the treatment of schistosomiasis since 1918. Although this drug provides effective therapy for schistosomiasis it has some drawbacks. First, it is quite toxic. Second, it must be given intravenously over a prolonged period.[1]

Stibophen (Faudin), a sulphonated catechol-antimony complex, has been used to treat schistosomiasis since 1929. This drug is administered intramuscularly. A course of approximately 20 injections given daily has been recommended. Stibophen also has significant toxic effects, particularly in undernourished individuals. Despite favorable reports concerning this drug our experience with it has not been ideal. A high relapse rate seen in our patients was due to recurrence of ova in the stool after treatment.

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Lucanthone Hydrochloride

Lucanthone hydrochloride (1-beta-diethylaminoethylamino-4-methylthioxanthone hydrochloride) was synthesized by Mauss in 1939. Kikuth and Gommert,[2] in 1948, screened approximately 4,000 compounds for activity against bilharzia organisms. They found lucanthone hydrochloride highly effective in treating experimental infections induced in laboratory animals.

Lucanthone hydrochloride is administered orally. It has had extensive clinical trial in recent years. A review of experiences with lucanthone hydrochloride in the treatment of schistosomiasis in various parts of the world was published by Blair.[3] He found that a comparison of the many clinical trials carried out in various different countries was difficult to make. There was, for example, variation in dosage and duration of treatment—also, in the criteria used for effectiveness of treatment in the reported studies. Blair noted that as a result of the first clinical trials in 1947, it was believed that S. *mansoni* was more difficult to eliminate with lucanthone than was S. *haematobium*. However, more recent studies indicate that S. *mansoni* infections responded equally well to treatment with this drug.

Additional studies of the treatment of S. *mansoni* infection with lucanthone hydrochloride have been reported from Brazil. Campos

et al[4] found only 20 per cent of a small series of cases apparently free from infection after treatment. Ferreira and Correa,[5] reporting on a series of 20 cases, found 95 per cent to be free of infection after a follow-up of several months. Peroba[6] reported a series of 25 cases in which 92 per cent were free of ova in the stool after a six month follow up. A series of 48 cases reported by Kloetzel[7] showed 72 per cent negative stools after a one-to-four month follow up. Einhorn et al[8] have recently reported the successful treatment of 41 of 45 children living in New York City with a follow up of 3 months to over a year.

Much of the variation in the results reported is probably related to marked differences in the patients treated in the various studies. It is evident that the patient groups varied greatly in age, race, nurition, severity and duration of infection, and the likelihood of re-exposure to infection after treatment. The period of follow-up in each study varied greatly. In few instances, however, was it possible to obtain adequate examination for long periods after administration of lucanthone.

Effect of Lucanthone on Fecal Excretion of *S. mansoni*

The purpose of this study was to investigate the effect of lucanthone hydrochloride on the fecal excretion of *S. mansoni* ova in patients who were living in a nonendemic area of the United States. It was felt that the drug would more likely cause favorable results in this group of patients than it would in a comparable group taken from an endemic area.

Puerto Rican patients living in Chicago were selected for this study. The ages of the 38 patients included in this series ranged from 9-to-50 years, with the average age being 22 years. The period of time that these persons lived in the continental United States varied from three months to 12 years. The average time was four and one half years. Only one patient in this series had advanced liver disease which was caused by schistosomiasis.

S. mansoni ova were identified in the stool of each person in the study. All of the patients in this study were in good nutrition. If heavily infected with other parasites, these patients were treated for those infections before therapy for schistosomiasis was instituted.

Each patient was given 10 mg. per kg. of lucanthone hydrochloride daily, in divided doses over a 7-10 day period. In most cases the treatment was given on an outpatient basis. A few individuals, however, received treatment in the hospital.

Adverse reactions to lucanthone medication were closely observed. If the patient was unable or unwillingly to continue therapy, the medication was discontinued before the completion of the full therapeutic course. The patients were followed in the clinic for as long as possible after the course of treatment had been completed. Stools were examined at regular intervals for schistosome ova. Toward the end of the study an attempt was made to purge as many of the patients as possible whose stools were still negative. As anticipated, a number of the patients in this group of economically deprived individuals were lost to follow-up.

Discussion

The results obtained in this study are summarized in Table 1. As will be noted, only 25 (66 per cent) of the 38 patients in this series were able to tolerate the drug well enough to complete the course of treatment. Younger individuals had little difficulty in tolerating the drug. Those of more advanced age were more

Table 1
Results of Treatment of S. mansoni Infection with Lucanthone Hydrochloride in a Nonendemic Area

	Total number of patients	Adequate follow up	Negative stools after therapy	Positive stools after therapy	Inadequate follow up
Totals	38	32	20	12	6
Number completing treatment	25	21	15	6	4
Incomplete treatment (failure to tolerate drug)	13	11	5	6	2

*For all listed negative three or more stools were examined 6 months (minimum) to 40 months after therapy.

likely to have significant toxic reactions.

There was considerable variation in the number of tablets which were taken before it became necessary to discontinue the medication among the patients who failed to tolerate the drug. The incomplete treatment group was thus quite heterogeneous, and several of the patients in this group had taken enough of the medication for it to have had a therapeutic effect on the parasitic infection. The toxic effects suffered by these patients included headache, nausea, vomiting, and malaise. All of these had previously been reported by other investigators. All toxic symptoms were relieved within a few days after discontinuing the medication.

The authors were able to obtain adequate follow-up examinations with 32 (84 per cent) of the 38 patients in this series. Adequate follow-up was arbitrarily defined as the examination of a minimum of three stools obtained six months or longer after treatment. In most cases, however, the follow-up period was one or more years, and it included numerous stool examinations.

Of the 32 patients in the entire group with adequate follow-up, 20 (63 per cent) had negative stools for six months or longer following therapy. Ten of the 20 patients with negative stools were purged. No schistosome ova were present in any of the purged stools. Of the 21 patients who completed treatment, 15 (71 per cent) had negative stools six months or more following therapy. The number of schistosome ova found in the stools of the patients who remained positive after treatment appeared to be significantly less than the number discovered before therapy. Reliable quantitative data in this regard are difficult to obtain. Thus no attempt has been made to estimate the degree of improvement on the basis of the number of ova found in the stool before and after treatment.

It should be noted that of the 11 patients with incomplete treatment who had adequate follow-up, five had negative stools six months or more following therapy. In general, those having negative stools after treatment completed a greater part of the course of therapy than those whose stools remained positive.

A large percentage of the patients treated with lucanthone hydrochloride volunteered the information that after the toxic effects of the drug wore off they felt much better than they had before therapy. Many stated that they no longer suffered from abdominal pain. Since it is difficult—on the basis of subjective reports—to distinguish psychogenic effects from true organic improvement, no analysis was attempted on the basis of these data. Significantly, many of the patients also gained weight shortly after treatment.

Conclusions

It is clear from this study that a large percentage of *S. mansoni*-infected Puerto Rican patients living in the continental United States will have negative stools six or more months after treatment with lucanthone hydrochloride. The results are in accord with those recently published by Einhorn et al.[8] These findings do not necessarily mean eradication of the infection, since *S. mansoni* may persist in the patient's body despite negative stools. This has been shown by rectal and by liver biopsy. The authors believe, however, that the persistence of negative stools after treatment indicates amelioration of the degree of infection. Statistical analysis, based on a comparison of the group which completed the course of medication with the incompletely treated group, would have little meaning because of the relatively small size of both groups and because of the heterogeneous nature of the partially treated group. It appears likely that some patients in the incompletely treated group received enough medication to have had a significant effect on the schistosoma infection.

The results obtained in this series of cases are superior to those published by some other investigators who have employed lucanthone hydrochloride in the treatment of *S. mansoni* infection.[3] It should be expected, however, that treatment of patients in good nutrition in a nonendemic area with relatively mild infection would produce superior results to those obtained by the treatment of poorly-nourished patients suffering from recent heavy infection in an endemic area. The superior results obtained by Einhorn et al[8] in comparison to the present series may be attributed in part to the use of a somewhat larger dose of lucanthone hydrochloride. It should also be noted that all of Einhorn's reported cases were children who

tolerated the drug sufficiently well to complete the treatment. In contrast, many of the patients in this series were adults who were unable to complete the course of treatment.

It should be recognized that because of the relatively small number of patients in our series, the authors were not able to control one variable. The authors realize that some of the patients in our treated group might have spontaneously reverted from positive to negative stools without treatment. Some patients with *S. mansoni* infection do, in fact, have alternation of positive and negative stools before treatment. It would therefore have been preferable to have had an untreated control group as part of a double blind study. The authors are of the opinion, however, that the spontaneous reversion of stools in our patients from positive to negative would have been of a much lower order than was obtained after treatment.

The authors believe that the results obtained by Einhorn et al[8]—and those of this study—justify the continued use of lucanthone hydrochloride in the treatment of *S. mansoni* infections, particularly in nonendemic areas. Cognizance must be taken of the drug's toxic effects which will prevent many patients—particularly in the older group—from completing the full course of medication.

Summary

The effectiveness of lucanthone hydrochloride in the treatment of schistosomiasis caused by *S. mansoni* in a nonendemic area was investigated by administering the drug in a dose of 10 mg. per kg. for a seven-to-ten-day period to 38 Puerto Rican patients living in Chicago. As a result of the toxic effects of the drug, the full course of medication was completed by only 25 of these patients. It was possible to obtain adequate follow-up stool examinations on 32 of the patients six months or longer after treatment. Negative stools were found in 20 of the group. Of the 21 patients adequately followed who completed the full course of medication, 15 had negative stools. Of the ten patients who were able to take only part of the medication and who had adequate follow-up, five had negative stools. Lucanthone hydrochloride appears to exert a favorable effect on the persistence and severity of S. *mansoni* infection in a nonendemic area.

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Endometriosis of the Umbilicus

Lawrence S. Mann, M.D.* and William R. Clarke, M.D.**

Endometriosis of the umbilicus is an uncommon lesion which may be defined as physiologically active ectopic mucosa located in the umbilicus.[1-9]

Theories Regarding Pathogenesis

It is interesting to speculate about how the uterine mucosa becomes situated in the umbilicus. There are several theories as to the pathogenesis. Latcher[5] has classified these theories into three main categories.

1. *The embryonal rest theory* which explains endometriosis adjoining the pelvic viscera by Wolffian or Müllerian remnants.
2. *The coelomic metaplasia theory* in which peritoneal cells or epithelial cells covering the ovary transform to endometrial tissue.
3. *The migratory pathogenesis theory* in which endometrial tissue is dispersed from the uterine cavity by diverse routes, including direct extension, vascular, and lymphatic.

All of these theories do not give a completely satisfactory explanation. It is most probable, therefore, that several mechanisms are involved. In the case to be described in this paper, there was evidence of endometriosis in the peritoneal cavity upon surgical exploration. Microscopic examination of the specimen suggested metaplasia of the stroma into epithelial-like elements.

Pathology, Diagnosis, Treatment

The gross pathological picture may reveal one or more tumors. These vary in size and have bluish hues. Bloody exudate may be present during catamenia, or it can occasionally be demonstrated upon pressure. Fibrosis in the subcutaneous tissue may be present. Microscopically, endometrial glands with surrounding endometrial stroma can be visualized.

The diagnosis is usually easy to make. Our patient had umbilical tenderness. This was more pronounced during her menstrual period with discharge of blood-tinged fluid from the umbilicus, which contained a tumor with bluish discoloration.

The preferred treatment is wide surgical excision of the lesion with exploration of the peritoneal cavity for other foci of endometriosis.

Case Report

A 34-year-old female was admitted to Roosevelt Memorial Hospital, complaining of bleeding from the umbilicus, which occurred during her menstrual periods for the past year and a half. This bleeding was accompanied by pain, swelling and tenderness in this area. The past history was non-contributory.

Physical examination revealed a 34-year-old married female weighing 134 pounds who did not appear acutely ill and with a blood pressure of 117/60 and pulse of 72. The umbilicus contained a small irregular tender mass from which blood tinged fluid exuded. The patient was menstruating. Other than the findings about the umbilicus, the physical examination was within normal limits. The hemogram, urogram, blood chemistry, chest x-ray and ekg were within normal limits.

Surgery

On 8-23-61 an enbloc excision of the umbilicus was performed through a double elliptical incision. The peritoneum and some of the omentum were adherent to this area. The peritoneal cavity was explored. Several adhesions were present. In the right pelvic area there was thickening with irregular raised areas. There were hemorrhagic areas extending the entire length of the umbilicus down to the peritoneum. In the abdomen numerous adhesions were present, as well as some

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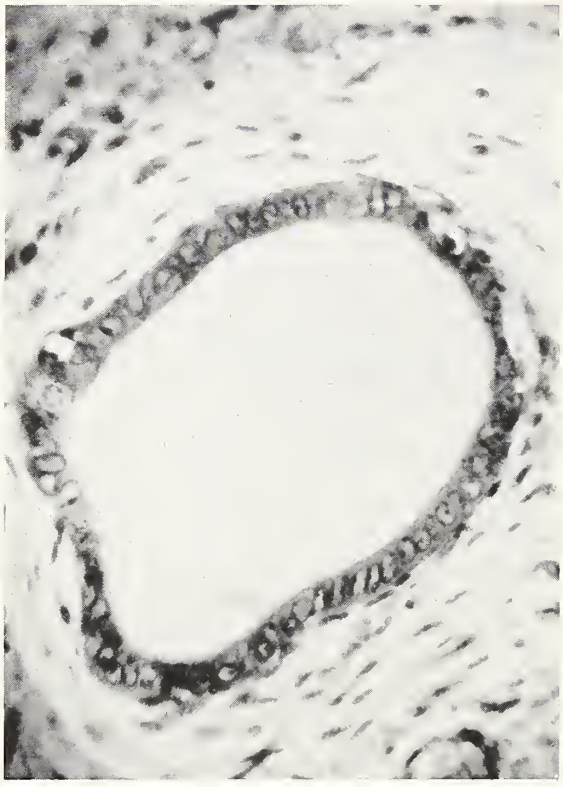


FIGURE 1. Endometriosis showing typical gland and stroma of endometrial type X 540.

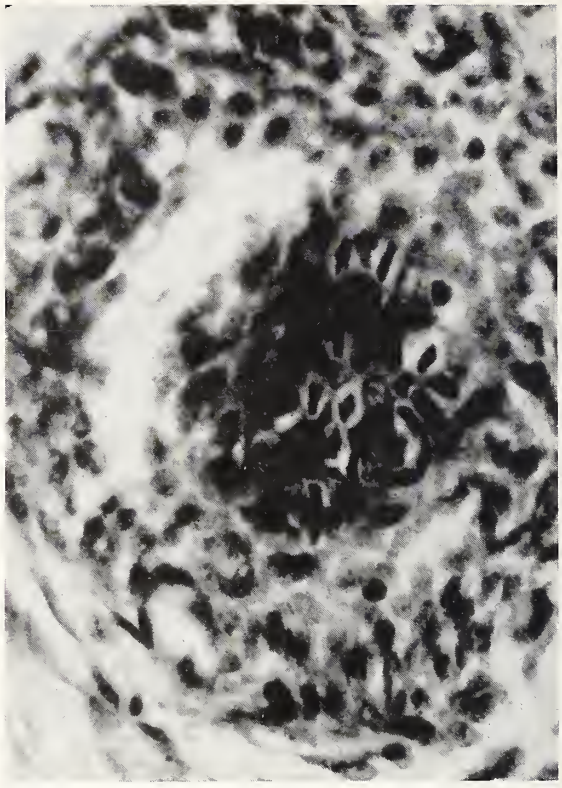


FIGURE 2. Endometriosis suggesting metaplasia of the stroma into epithelial-like elements X 540.

irregular areas which were thought to be endometriosis. The peritoneum was then closed with a catgut suture. The anterior and posterior rectus sheaths were repaired with interrupted sutures. The remainder of the closure was in layers. The post-operative course was uneventful. The sutures were removed on the 12th post-operative day and the patient was discharged.

Pathology

The pathological diagnosis, made by Dr. R. J. Stein, was endometriosis, ectopic, umbilicus. The formalin fixed specimen consisted of an ellipse of skin with the umbilicus measuring 8 x 2 cm. In the center there was a nodular elevation measuring 0.6 cm. in diameter. The subcutaneous fatty tissue contained a round mass measuring 2 cm. in diameter. The sectioned surface showed a hemorrhagic focus as well as dense fibrous tissue which was continuous with the above described nodular mass within the umbilicus.

Microscopic Findings

Multiple sections showed endometrial glands with its surrounding endometrial stroma. Some of these glands showed focal hyperplasia, however no atypical changes were noted (Fig. 1). The surrounding connective tissue stroma showed foci of edema as well as an infiltrate consisting of lymphocytes. Figure 2 shows a microphotograph suggesting metaplasia of the stroma into epithelial-like elements, which may be a clue as to pathogenesis.

Summary and Conclusion

A case of umbilical endometriosis in a 34 year old female is presented.

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Diabetes Mellitus in One of Identical Twins

By Howard S. Traisman, M.D.*
Richard A. Gatti, M.D.*

Present evidence strongly suggests that diabetes mellitus is a disease of autosomal recessive inheritance. The phenomenon of diabetes appearing in only one of a set of identical (monozygotic) twins does not lend support to this mode of inheritance. While such a case might suggest an environmental etiology for this disease, more careful analysis of previously reported discordant (dissimilar) identical twins[1-9] reveals that the non-diabetic twin may actually be a prediabetic. The purpose of this paper is to present and discuss such a set of twins.

Case Reports

Karen F., a four year old, white female, was first seen at this hospital on June 15, 1953, with the chief complaint of bed-wetting. It was difficult to establish the onset of her bed-wetting because, unlike her twin sister, the bed-wetting had persisted intermittently since infancy. A two week history of polydipsia, polyuria, polyphagia, and weight loss was elicited. There was no family history of diabetes. Physical examination was negative.

Laboratory studies revealed a normal hemogram. Urinalysis showed four-plus sugar and two-plus acetone. A glucose tolerance test was performed on June 16, 1953, and yielded a diabetic-type curve: fasting blood glucose, 145 mg. per 100 c.c.; ½ hour, 266 mg. per 100 c.c.; 1 hour, 271 mg. per 100 c.c.; 2 hours, 315 mg. per 100 c.c.; 3 hours, 266 mg. per 100 c.c. (Table 1). Karen did moderately well with a weighed diabetic diet and intermediate-acting insulin.

The twins were born on March 18, 1949. They were three weeks early. The mother had mild toxemia with moderate hypertension and albuminuria late in her pregnancy. A pre-eclamptic regimen of magnesium sulfate and sedation was prescribed. Kathy F., the non-diabetic twin, was born first by spontaneous breech delivery. She weighed 5 pounds, 11 ounces. Karen weighed 5 pounds, 14 ounces, and was a cephalic presentation. A single, intact placenta was delivered 25 minutes after the second birth. Both infants did well in the immediate postnatal period. Motor development was normal for both girls.

TABLE 1

	DATE	TEST	FBS	1/2	1	1 1/2	2	3
KAREN (DIABETIC)	6-53	GTT	145	266	271	——	315	266
KATHY (NON-DIABETIC)	2-62	GTT	72	155	113	113	100	86
	12-62	GTT	70	122	112	77	88	90
	2-62	CGTT	87	150	120	100	74	72
	3-63	CGTT	85	128	142	107	101	101

Kathy F., the four year old identical twin of Karen, was also seen on June 15, 1953. She had a short history of bed-wetting. This had subsided at three years of age. She had no signs or symptoms of diabetes. Physical examination was unremarkable except for the marked resemblance to her sister (Figure 1) and a nevus flammius all along the extensor surface of her right arm. She weighed 37 pounds, three pounds more than Karen. When diabetes was discovered in her twin sister, Kathy's urine was tested for sugar, and acetone was found to be negative. Fasting blood sugars at 6 and 8 years of age were normal. A glucose tolerance test was not performed on Kathy until she was 13 years old. On February 1, 1962, the glucose tolerance test was as follows: fasting blood sugar, 72 mg. per 100 c.c.; ½ hour, 155 mg. per 100 c.c.; 1 hour, 113 mg. per 100 c.c.; 1½ hours, 113 mg. per 100 c.c.; 2 hours, 100 mg. per 100 c.c.; 3 hours, 86 mg. per 100 c.c. (Table 1).

On February 4, 1962, a cortisone-glucose tolerance test was performed, and it yielded normal results: fasting blood sugar, 87 mg. per 100 c.c.; ½ hour, 150 mg. per 100 c.c.; 1 hour, 120 mg. per 100 c.c.; 1½ hours, 100 mg. per 100 c.c.; 2 hours, 74 mg. per 100 c.c.; 3 hours, 72 mg. per 100 c.c. (Table 1). No glycosuria was found during either tolerance test. At that time, a hemogram, blood urea nitrogen, liver profile, serum cholesterol level, and protein-bound iodine were all within normal limits. An EEG, chest x-ray, IVP, and upper GI series were also normal. These tests were performed because of psychosomatic complaints.

Kathy's glucose tolerance test was repeated in December, 1962. It was essentially unchanged: fasting blood sugar, 70 mg. per 100 c.c.; ½ hour, 122 mg. per 100 c.c.; 1 hour, 112 mg. per 100 c.c.; 1½ hours, 77 mg. per 100 c.c.; 2 hours, 88 mg. per 100 c.c.; 3 hours, 90 mg. per 100 c.c. (Table 1). Repeated urinalyses have been negative. Fasting blood sugars have been consistently in the eighties.

On March 5, 1963, the cortisone-glucose tolerance test was repeated: fasting blood sugar, 85 mg. per 100

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FIGURE 1

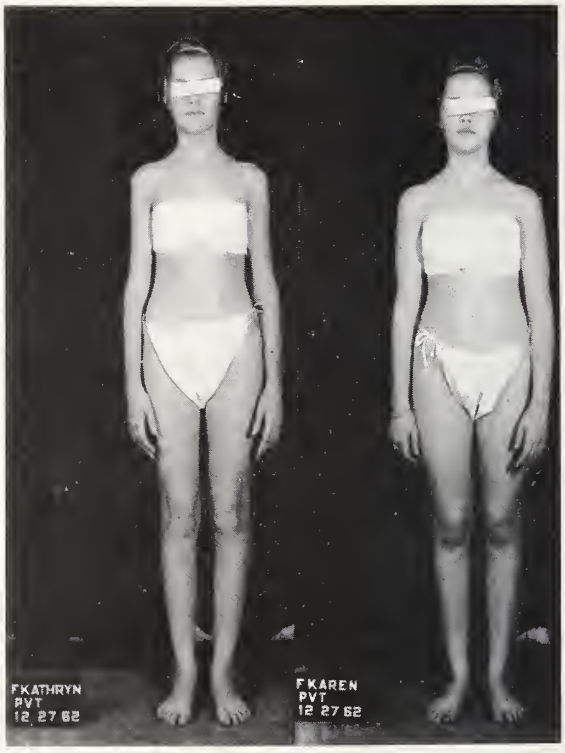


FIGURE 2

c.c.; ½ hour, 128 mg. per 100 c.c.; 1 hour, 142 mg. per 100 c.c.; 1½ hours, 107 mg. per 100 c.c.; 2 hours, 101 mg. per 100 c.c.; 3 hours, 101 mg. per 100 c.c. (Table 1). No glycosuria was observed during this test. Our method of performance and interpretation of these tolerance tests was as outlined by Conn and Fajans.[10]

The girls are now fourteen years old (Fig. 2). The non-diabetic is approximately two inches taller; the diabetic is approximately ten pounds heavier. Karen's diabetic control has been especially good during the past three years. Obviously, the girls no longer appear identical. Recent fingerprint analysis by the Federal Bureau of Investigation showed their pattern types to be quite similar, as would be expected in monozygotic twins.[11] Blood factors sent to the Ortho Research Foundation in Raritan, New Jersey, were also concordant in all but the P system:

TABLE 2

	D	C	E	c	S	s	Fy^a	Fy^b	K	k	P*	probable genotype
Karen AM	O	O	O	+	−	+	+	−	−	+	−	Rh neg. rr (dce/dce)
Kathy AM	O	O	O	+	−	+	+	−	−	+	+	Rh neg. rr (dce/dce)

*"A discrepancy exists in the P system only. Frequently, the P_1 antigen is difficult to detect, particularly in those individuals who have inherited a weak antigen. This may be true in the case involved."

This discrepancy is insignificant according to the report from the above laboratory.[12] It is of interest that neither of the twins, as yet, has begun menstruating.

Discussion

Although diabetes mellitus was first described by Aretaeus around 100 A.D.,[13] its hereditary aspect was not discussed until 1696, when Morton recorded a family in which four of the children were diabetic.[14] In 1929, Curtis reported ten sets of concordant diabetic identical twins. His paper was a collection of three cases of his own and seven cases from the literature dating back to 1904. In this paper, he recorded the interval of time which elapsed between the development of diabetes in each set of twins. This varied from a simultaneous discovery of onset to forty-eight years apart.[1]

In 1939, Then Berg made the observation on her large series of identical and fraternal, concordant and discordant twins, that after the age of 43 all her identical twins were, or had become, concordant for diabetes. This suggests that if one waits long enough, all discordant identical twins will become concordant.[4] It is also of interest that she reported the incidence of concordant diabetic twins to be higher among the monozygotic sets than among the dizygotic. Joslin recently published figures in

agreement with Then Berg's observation of 25 years ago. Among his patients, 48 per eent of identieal twins were eoncordant for diabetes, as eompared with three per eent eoneordanee in the dizygotie twins.[15]

Some investigators have suggested that the time of onset or expression of this disease is also based on hereditary prineiples.[19] Aeeording to these investigators, one ean antieipate the onset of the disease in the offspring, depending upon the age of onset of elinical diabetes in previous generations. Steinberg eontends that, "Among ehildren of diabeties the younger age of onset of diabetes is a statistieal but not a biologieal phenomenon."[17] He states that, "Coneordanee among identieal twins is not complete, henee postnatal environmental faetors are important in determining the oecurrenee of frank diabetes."[14] This suggests that Steinberg also believes that there is an environmental influenee on the elinieal expression of diabetes.

One does not have to look far to find an example of an environmental diabetogenie influenee. There are many bona fide studies of pregnant women with diabetie glueose tolerance eurves and eortisone-glueose toleranee eurves whieh have later returned to normal in the immediate postpartum period.[18] Somehow, pregnaney taxes glueose homeostasis. Another ten-year follow-up of Kathy (the non-diabetie twin) through the ehild-bearing age should prove interesting in this respeet. Sueh individuals are good subjects for evaluating new methods of distinguishing the prediabetic from the normal person.

In a large percentage of the above eited women, frank diabetcs will later develop. It is often impossible to separate all the prediabetics from the normal patients, and many diabeties eannot be distinguished from the prediabeties. Jaekson describes four main groups of prediabeties by history alone:

(1) Mothers of over-large babies and stillbirths; (2) Children of two diabetie parents; (3) An identieal twin of a diabetie patient; and (4) A person with a parent and a child who are diabetie, but with no diabetes in the spouse's family.[18]

The diagnosis of "prediabetes" ean only be eonfirmed in retrospeet, and often not even then should the prediabetie meet a premature death. Such eases make statistieal evaluation very difficult.

Summary

The monozygotic twins reported here became diseordant at four years of age, when one developed diabetes mellitus. Ten years later, the seeond twin is still non-diabetie. This appears to challenge the autosomal reeessive mode of inheritanee of diabetes, and suggests an environmental etiology for this disease. However, past studies of this same phenomenon have shown that eventually the non-diabetie twin will also develop diabetes and, therefore, must be considered prediabetie. Another ten year follow-up of this non-diabetie twin through the ehildbearing age should prove interesting.

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ISMS Annual Convention May 17-21

The View Box

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital
Chicago, Illinois

This 65 year old, white female entered the hospital with complaints of nausea, vomiting, and swelling of both legs. She was a pork eater.

Physical examination revealed a well developed female, with a temperature of 101°F., and a faint systolic murmur over the apex. The lungs were clear. Bilateral swellings of both legs from the ankles to the knees were noted, with superficial and deep varicose veins present.

A laboratory test revealed 15,000 WBC's, 68 per cent PMN'S, 28 lymphocytes, 4 per cent eosinophiles.

What is your diagnosis?
(1) Trichinosis
(2) Subcutaneous ossification of the legs due to varicosities
(3) Hemangioma of soft tissue
(4) Myositis ossificans



Figure 1.

REFERENCE

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Calls Will Reach You Easily at '64 Convention



Doctor, please inform your staff that while you are attending the ISMS Convention you may be reached through the Physicians' Message Center. Here is the number to remember:

312-332-5742

This is a direct connection which does not go through the hotel switchboard.

MAY 17-21 SHERMAN HOUSE

The History of Neurology in Chicago

ROLAND P. MACKAY, M.D., *Chicago*

This is the fourth installment of an informative history of neurology not only in Chicago as the title would indicate but throughout the state and the nation. In a delightful and interesting style, Dr. Mackay paints a picture of the growth of neurology as seen against the times in which it was practiced—a story of a city and specialty growing together.

Hugh Talbot Patrick, surely the most influential and renowned neurologist ever to practice in Chicago, was born of Scotch-Irish descent, in New Philadelphia, Ohio on May 11, 1860. His grandfather had come from Belfast to New Philadelphia in 1817 and had founded the first newspaper in his county; his father had been an Ohio State Senator. He himself graduated in medicine at the Bellevue Hospital Medical College in 1884 and, after an internship, came in 1886 to Chicago to practice. He was the first Chicago neurologist to enter the field without serving in a state hospital for the insane. Instead, he did postgraduate work in Germany, France and England, where he made friends of many scholars, with whom he corresponded frequently and for whom he became the only known neurologist in the middle west. He became Professor of Nervous and Mental Diseases in the Chicago Polyclinic, and in 1895 was appointed Instructor in Northwestern University Medical School, rising regularly through intermediate grades to full Professor of Nervous and Mental Diseases in 1902, and Emeritus Professor in 1919. He served as Attendant Physician in Neurology at Wesley, Passavant, People's and Henrotin Hospitals and was Consultant at St. Anthony and Illinois Charitable Eye and Ear Infirmary. He was one of the founders of the Chicago Neurological Society, its first secretary and twice its president. Elected to memebership in the American Neurological Association in 1896, he was its president in 1907. A host of other societies in diverse fields of medicine knew his as a member, many as president. His scientific



Hugh Talbot Patrick (1860-1939)

writings were many; he founded the Archives of Neurology and Psychiatry in 1918 and was its first Chief Editor, as he was Editor for years of the Year Book of Neurology and Psychiatry. In 1936 he was honored with an issue of the Archives of Neurology and Psychiatry dedicated to him. Many other honors were conferred upon him, including Chevalier of the Legion of Honor of France, and D.Sc. by his own Northwestern University in 1927.

He reigned supreme over Chicago neurology, and an association with him was eagerly sought by aspirants to neurologic skill. Among his personal pupils were Peter Bassoe, Lewis J. Pollock and Harry Paskind, but his influence and inspiration touched many others, such as Julius Grinker as related below. He was a most effective teacher, whose unerring flair for the essential enabled him to disregard the irrelevant and strike dramatically, with economy of phrase, to the heart of the case at hand. He was all but exclusively a neurologist; his insight into psychiatry was meager. A voluminous

bibliography reveals the enormous breadth of his neurologic interests, but stamps him as purely a clinician—such research as he did was observational and directed to his patients. In his writings his descriptions are etched, simple and essential, without frills. His sharp tongue was witty and often caustic; modesty was no virtue of his. It has been said that he was never without an answer—except on one memorable occasion. His superb self assurance imparted confidence in his capacity and integrity, and his word was usually accepted as gospel. As Bassoe, his first personal assistant and pupil said of him, "There was little scientific neurology in Chicago before you. . . ." One may truthfully say that with him neurology in this city came finally of age.

In his later years, after retirement, he devoted his interests chiefly to medica and neurologic history. He died January 1939, but he left to his successors a great heritage of scientific method in clinical neurology, of a canny eye for the genuine, and of rigorous adherence to the facts.

Archibald Church, born in Fond du Lac, Wisconsin, March 23, 1861, was an almost exact contemporary of H. T. Patrick. He graduated in 1884 from the College of Physicians and Surgeons in Chicago and at once became Attending Physician in the Northern Illinois Hospital for Insane, later Elgin State Hospital. In 1888 he moved to Chicago and joined the faculty of the Chicago Medical College as lecturer on Insanity and Medical Jurisprudence just a year after the great Jewell's death in 1887. Within 5 years, in 1893, when the World's Columbian Exposition was in full bloom, he was appointed Professor of Mental Diseases and Medical Jurisprudence at Northwestern University Medical School, where he served for the next 25 years, latterly as chairman of the department. He was also Professor of Neurology at the Chicago Polyclinic and Hospital and had hospital connections at St. Luke's, Michael Reese, Wesley Memorial, Chicago Lying-In, Cook County and St. Barnabas. He was Special Consultant in Neuropsychiatry to the United States Public Health Service. In 1927 he received the D.Sc. degree from his own university. He wrote numerous papers ranging the whole field of neurology and phychiatry but



Archibald Church (1861-1952)

his opus magnum was his textbook of *Nervous and Mental Diseases*, with Frederick Peterson of New York as joint author. The first edition appeared in 1899; eight other editions followed.

Church was tall, broad of shoulders, meticulously dressed, courtly and impressive. He was well read in his field and gave well prepared, literate lectures which were popular. He was a member of the unique "Chicago Medical Club," a semi-secret, self-appointed group called also the "Chicago South Side Medico-Social Society" and sometimes "The Twenty-Second Street Gang." With members drawn largely from Rush, the College of Physicians and Surgeons and Northwestern University Medical School, it was organized in 1883, met monthly near Twenty-Second Street and Wabash, and contrived, along with its own amusement, discussions and reminiscences, a great fund of medical political power. It indulged in no publicity, but exerted its influence through its members' mutual relationships and combined personal leverage in moulding the careers of others. The organization is well described by Dr. James B. Herrick in his *Memories of Eighty*

Years.[16] One gathers that it was a group of congenial cronies, exclusive and self-contained, operating to promote whom they wished and restrain the rest. As the members died or became inactive, and their numbers few, the club voluntarily disbanded in its fiftieth year, 1933. Church must have been almost the last, when he died on May 8, 1952.

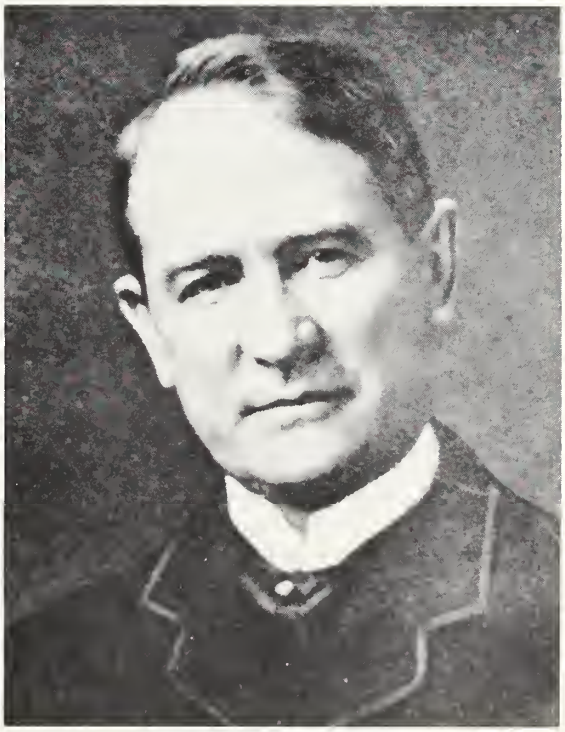
James Cornelius Gill was born on his father's farm in Wisconsin, October 12, 1863, graduated in medicine from Rush Medical College in 1890, and after internship at the Presbyterian Hospital, associated himself with Dr. Daniel Brower. A quiet, unassuming neuropsychiatrist, he lectured at Rush Medical College for over 40 years, becoming Clinical Professor of Neurology in 1925. He was Consultant Neurologist at the Presbyterian, Illinois Central and Illinois Masonic Hospitals and Attendant Psychiatrist at the Cook County Psychopathic Hospital. He was a Fellow of the Institute of Medicine from its foundation in 1925, and member of the Chicago Neurological Society and the Central Neuropsychiatric Association. He died in 1935.

Sanger Brown was one of many Canadians who served illustriously as physicians in the United States. He was born February 16, 1852 at Bloomfield, Ontario, had his preliminary education at Toronto and Belleville, Ontario, and graduated in medicine in Bellevue Hospital Medical College in New York in 1880. He was appointed Assistant Physician at Ward's Island Hospital for the Insane, where he reclassified the patients and was able to discharge many. He then served as Assistant Physician at Danvers, Massachusetts State Hospital for the Insane in 1881, and at the Bloomingdale Asylum, White Plains, New York, from 1882-6, being Acting Medical Superintendent during his final year there. After a year, 1886-7, in research with E. A. Schaefer at the University College, London, during which he proved that the center for vision in monkeys is in the occipital lobes, he came to Chicago in 1890 and soon was a prominent neurologist and psychiatrist. He was Professor of Medical Jurisprudence and Hygiene at Rush from 1892-7, and Clinical Professor of Neurology at the Illinois College of Physicians and Surgeons thereafter. For many years he was Attending Neurologist at the Cook County, St. Luke's and St. Elizabeth's Hospitals, and was Proprietor and Medical Director of the Kenilworth Sanitarium.

In Sanger Brown's office on January 5, 1898 a meeting was attended by some 20 physicians, neurologists, psychiatrists and others, where



James Cornelius Gill (1863-1935)



Sanger Brown (1852-1928)

the Chicago Neurological Society was founded. They were, in alphabetical order, J. J. M. Augear, H. M. Bannister, Daniel R. Brower, Sanger Brown, Archibald Church, N. S. Davis, Jr., Richard S. Dewey, H. H. Donaldson, M. L. Goodkind, Philo L. Holland, J. G. Kiernan, Oscar A. King, Sidney Kuh, C. H. Lodor, Jacques Loeb, Henry M. Lyman, Harold N. Moyer, Hugh T. Patrick, Otto Schmidt and E. Wing. The following officers were elected: President, Sanger Brown; Vice-President, Oscar A. King; Recording Secretary, Sidney Kuh; Corresponding Secretary, Hugh T. Patrick, and Counselor, the venerable Henry H. Lyman. Exactly 3 months later, on the evening of April 5, 1898, when, as Harry A. Paskind writes,[17] the weather was cold and snow falling, a small group of men dined together in the Touraine Room of the Grand Pacific Hotel, after which F. L. Holland and Charles H. Lodor read papers. Others later joined the society but many, like some of the "founding fathers," were neither neurologists or psychiatrists, but simply physicians with broad interests, ready to hear what was being thought about diseases of the nervous system.

Thus Sanger Brown may be said to have been accoucheur at the birth of the Chicago Neurological Society. Thereafter he was active in the organization and was again its president in the year 1925-6. At the May 1926 meeting he gave a historical sketch of the society, being then 74 years of age, and, like all other men, interested in history. In the meantime, he had been elected to membership in the American Neurological Association in 1908 an dhad contributed freely to its deliberations. He died April 1, 1928 at the Presbyterian Hospital, following prostatectomy.

Read before the International College of Surgeons, Chicago, Illinois, March 19, 1963. Excerpts of this article appeared in the Journal of the International College of Surgeons, August, 1963 under the same title.

Professor of Neurology, Northwestern University Medical School, and Senior Attending Neurologist, Chicago Wesley Memorial Hospital.

*For much of the material here presented on the general history of Chicago, I am deeply indebted to Emmett Dedmon's *Fabulous Chicago*.[1]

The View Box

(Continued from page 340)

Diagnosis: Subcutaneous ossification of the legs due to varicosities

This is a common condition, present in about 10 per cent of chronic varicosities. It occurs in patients usually over 50 years of age and more frequently in women.

Pathologically, it is a cancellous bone deposition in the subcutaneous tissues, not in the dilated veins themselves. It is frequently associated with recurrent ulceration of the leg. Venography demonstrates the subcutaneous nature of the deposits outside the venous structures.

General Assembly Speaker

Hugh H. Hussey, M.D.

Director, Division of Scientific Activities American Medical Association

"Problems Related to New Drugs"

A New Look at the Illinois Medical Practice Act

Philip G. Thomsen, M.D., *Chairman, ISMS Medical Examining Committee*

Medieal licensure in the state of Illinois is predicated on terms set forth by the Medical Practice Act. This Act is implemented by the Illinois State Department of Registration and Education, and it is administered by the Director of that Department.

Types of Licenses for MDs

Doctors of medicine are authorized to practice their profession under terms stipulated by one of three different types of licenses. These are:

(1) *State Hospital Permit.* This category was established in recent years to particularly help staff mental institutions. It permits a medical graduate to practice only in certain specified state institutions.

(2) *Temporary Certificate of Registration.* Also established in recent years, this type of registration permits a medical graduate to enroll in one of several approved postgraduate programs being offered in the state of Illinois. Under this temporary certificate, his practice is limited to activity within the prescribed confines of the postgraduate program in which he participates.

(3) *Full Licensure.* All doctors of medicine who do not practice under the jurisdiction of either of the above mentioned categories do so under the dictates of full licensure. This full license can be obtained only by examination or by reciprocity.

Fees For Examination and Registration

The state legislature sets the fees that are to be charged for examination and registration under the Medical Practiee Act. Several years ago an amendment to the Act—passed with the support of ISMS—made it mandatory for licensees to re-register every two years. In the last session of the legislature, ISMS supported a measure which would increase the fee for re-registration. It was understood that the additional revenue thus derived would be used to finance improved methods whereby the Medical Practice Act could be more thoroughly enforced.

The Director of the Department of Registration and Education has served notice that such a stepped-up program of enforcement of the Act will be implemented immediately. This program will consist of several phases. These include:

(1) Obtaining from every hospital data pertaining to the licensure status of every M.D. who is in any way associated with that hospital.

(2) Making more frequent visits to each practitioner's office to make sure that each individual who represents himself as an M.D. is, in fact, legally authorized to do so.

(3) A continuing effort will be made to assure the Department that all chiropractic and osteopathie physicians who practice within the state of Illinois are properly licensed to do so.

(4) There will be increased supervision of nurses' registration and of nursing education within the state.

Significance of Stepped-up Enforcement

The accelerated enforcement of the Medical Practice Act will not, of course, affect the properly licensed practitioner in any way. It will, however, have some adverse affects on certain hospitals—particularly those that depend rather heavily on the services of unlicensed foreign medical graduates. Such medical graduates are being used to staff hospital emergency rooms and to perform other hospital duties. A considerable number of these unlicensed medical graduates will certainly be barred from practicing medicine in Illinois.

A certain degree of hardship will undoubtedly be inflicted on some hospitals because of the accelerated prosecution of the Medical Practice Act. It should be borne in mind, however, that anyone who diagnoses an ailment, prescribes treatment for an ailment, or who in any way cares for a patient is indeed practicing medicine. If such a person is not licensed to practice medicine, the hospital where he works —and also the staff of that hospital—are liable not only to malpractice suits but to citation under the Medical Practice Act as well.

"Talk Fees First"

Arkell M. Vaughn, M.D.,* *Chicago*

One of the most frequently encountered problems involved in the physician-patient relationship has to do with *fees.*

It is impossible for a patient to know what his medical treatment will cost unless his physician informs him. Many physicians, of course, are afraid of sounding too "commercial." This, they feel, will "frighten the patient off," particularly if they broach the subject of fees at the outset of treatment. Consequently, many patients do not find out about the cost of their medical care *until they receive a bill.*

The disastrous results of such tardy communication and misunderstanding concerning fees is pointedly demonstrated in our annual county society grievance committee survey for 1963. Of 441 reported grievances reported last year, 213—*or nearly 50 per cent*—involved fees. Almost twice as many of these complaints were settled through satisfactory *explanation,* rather than through reduction of the fees. This latter fact underscores the absolute necessity for the physician to clearly inform his patients about fees *before* rendering service.

But how can such a delicate subject be approached without embarrassment to the patient—*and* to the physician? Perhaps the best way is thoughtful anticipation of *every* patient's concern for how much *your* services are going to cost *him.* He should be encouraged to participate in a tactful, considerate discussion of the subject.

Now, how can this be accomplished? You may, after a brief description of the treatment that you deem necessary, safely "break the ice" with a statement such as this, "Well, Mr. Jones, I think it is safe to estimate that the cost of your treatment won't be any more than $——." When you have quoted this anticipated cost, invite the patient to inquire about: (1) The considerations involved in arriving at this figure, (2) the standards by which you estimated this cost, and (3) the terms of payment that you will accept.

Such complete candidness will invariably place your patient at ease. It will also tend to make him more amenable to treatment. Finally, it may save you the humility and embarrassment of being unjustly brought before your local grievance committee.

It is frequently possible to induce your patient to take the lead in bringing up the subject of fees. Perhaps the simplest and most effective method of helping the patient to stimulate a discussion of fees is to have a large sign placed in your waiting room which might read:

> *"TO ALL OF MY PATIENTS*
>
> I invite you to discuss frankly with me *any* questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between doctor and patient."

An attractive sign bearing this invitation is available at a cost of $1.25, postpaid, from the American Medical Association, 535 North Dearborn, Chicago, Illinois.

Very often such public expression of your willingness to discuss fees will allay any doubts or fears that your patient may have. It will also obviate the need for a straightforward lengthy discussion when the subject is brought up.

The physician has a right to charge his patient a fee that he thinks is ethical, fair and appropriate. This right represents one of the cornerstones upon which our free enterprise system of medicine is built. Whenever a complaint concerning fees is filed with a medical society grievance committee, it not only places the personal reputation of the individual physician in jeopardy, it offers the proponents of socialized medicine additional mortar with which to foritfy their story.

To prevent rather than have to correct these problems, make the slogan *talk fees first* an unshakable working rule in your practice.

*Chairman, Committee on Grievances, Illinois State Medical Society.

Program Summary—ISMS Convention

Sunday, May 17

8:30 a.m.—Disaster Medieal Care Committee
Orehid Room 106

12 Noon—Registration for Officers and Delegates Mezzanine

12 to 4:00 p.m.—Finance and Exeeutive Committees Ruby Room 113

12 to 4:00 p.m.—Reference Committee Chairmen
Life Room 108

4 to 5:00 p.m.—Board of Trustees Meeting
Gold Room 114

5 to 6:30 p.m.—Board of Trustees Dinner
Ruby Room 113

6:00 p.m.—Illinois Soeiety of Obstetrics & Gynecology Board Dinner
Time Room 110

7:00 p.m.—House of Delegates
Louis XVI Room

9:00 p.m.—Mexican Party
Bernard Shaw Room

Monday, May 18

8:00 a.m.—Board of Trustees Breakfast
Ruby Room 113

8:30 a.m.—Registration
Mezzanine

9 to 12:00—Referenee Committees:
Administration
Old Chieago Room 101
Publications & Scientific Services
Holiday Room 105
Eeonomics
Orehid Room 106
Legislation
Freneh Room 107
Constitution
Life Room 108
Publie Relations
Time Room 110
Miseellaneous
Gold Coast Room 111

9 to 5:00 p.m.—Illinois Soeiety of Obstetries & Gynecology
Gold Room 114

12:00 to 2:00 p.m.—Illinois Soeiety of Obstetrics & Gyneeology Luneh
Jade Room 103

12:00 noon—Impartial Medieal Testimony Luneh
Bal Tabarin

1:30 p.m.—Combined Meeting—Illinois Surgieal Soeiety & ISMS Seetion on Surgery
Louis XVI Room

2:00 p.m.—Seetion on Anesthesiology
Freneh Room 107

2:00 p.m.—Seetion on Neurology & Psyehiatry
Crystal Room

4:00 p.m.—IMPAC Annual Meeting
Old Chieago Room 101

6:00 p.m.—Publie Affairs Reeeption and Dinner
Bal Tabarin

6:00 p.m.—University of Illinois Dinner
Crystal Room

Tuesday, May 19

8:00 a.m.—Board of Trustees Breakfast
Ruby Room 113

8:30 a.m.—Registration
Mezzanine

8:30 a.m.—Auxiliary Board
Orehid Room 106

9 to 5:00—Auxiliary
Bernard Shaw Room

9 to 12 a.m.—Section on Dermatology
Old Chieago Room 101
Section on Allergy
Louis XVI Room
Seetion on Ob-Gyn
Crystal Room

9 to 12 a.m.—Referenee Committees
Life Room 108
Time Room 110
Gold Coast Room 111

10:00 a.m.—Illinois Physieians Association
Jade Room 103

12:15 p.m.—Publie Health Luneh
Freneh Room 107

(Continued on page 348)

Program Summary—continued

12:30 p.m.—Fifty Year Club
Louis XVI Room
2 to 5:00—Section on Public Health
Gold Room 114
Section on Physical Medicine
Old Chicago Room 101
Section on Radiology
Crystal Room
5:00 p.m.—Radiology Reception
Skyline Terrace
6:30 p.m.—Illinois Chapter, American College of Chest Physicians Dinner
Crystal Room
7:00 p.m.—House of Delegates
Louis XVI Room
8:00 p.m.—Committee on Medicine and Religion, ISMS and Catholic Physicians' Guild of Chicago
Bal Tabarin

Wednesday, May 20

8:00 a.m.—Board of Trustees Breakfast
Ruby Room 113
8:30 a.m.—Registration
Mezzanine
9 to 12:00—Auxiliary
Bernard Shaw Room
9 to 12:00—Section of Pathology
Louis XVI Room
Section on Pediatrics
Crystal Room
11:00 a.m.—Illinois Society of Internal Medicine
Jade Room 103
Noon—ISIM Luncheon
Jade Room 103
Illinois Academy of General Practice Luncheon
Old Chicago Room 101
12:30 p.m.—Illinois Society of Pathologists Lunch
Orchid Room 106
1:00 p.m.—Auxiliary Luncheon & Style Show
Hotel Continental
2:00 p.m.—Illinois Academy of GP Board of Directors
Time Room 110
2:30 to 4:30 p.m.—General Assembly—Camp Memorial Lecture
Louis XVI Room
6:00 p.m.—Reception
Louis XVI Room
7:00 p.m.—Banquet
Ballroom

Thursday, May 21

8 to 5:00—Section on E.E.N.T.
Gold Room 114
8:30 a.m.—Registration
Mezzanine
9 to 11:00 a.m.—Medical Business Management
French Room 107
9 to 11:00 a.m.—Speech Training Clinic
Jade Room 103
9 to 12:00—Auxiliary
Bernard Shaw Room
9 to 12:00—House of Delegates
Louis XVI Room
Noon—Auxiliary Luncheon
Bal Tabarin
Noon—Board of Trustees Luncheon
Crystal Room
Noon—Flight to Mexico
3:00 p.m.—Auxiliary Board
Orchid Room 196

Friday, May 22

9:00 a.m.—Symposium in Mexico City (See Program for Details)

AT YOUR SERVICE DURING CONVENTION . . .

Registration . . . . . **Mezzanine**
Message Center . . . . . **Mezzanine**
Press Room . . . . . **Polo Room**
Business Office . . . . . **Emerald Room**
Technical Exhibits . . . . . **Mezzanine**
Scientific Exhibits . . . . . **Mezzanine**
Scientific Movies . . . . . **Mezzanine**
Convention Manager . . . . . **Mezzanine**

Convention Program by Days

Monday, May 18

SURGICAL SYMPOSIUM
ILLINOIS SURGICAL SOCIETY

Chairman ..... Chester C. Guy, M.D.

Cook County Hospital—7th Floor
Harrison and Wood Streets

SURGICAL AMPHITHEATER

8:00-10:30 a.m.—Abdominoperineal Resection for Carcinoma of the Colon—Surgeon, Peter A. Rosi, M.D.

Discussion of Indications for Anterior Resection—R. Kennedy Gilchrist, M.D.

Management of Perineal Recurrence—J. C. Thomas Rogers, M.D.

HEKTOEN INSTITUTE AMPHITHEATER

11:00-12:00 a.m.—Surgical Management of Carcinoma, Case Presentation and Discussion—Henry T. Randall, M.D., Professor of Surgery at Columbia Medical School, Director of Memorial Center for Cancer and Allied Diseases, Sloan-Kettering Institute for Cancer Research, New York, New York

OPERATING ROOM A

8:00-10:30 a.m.—

Moderator: Frederic A. dePeyster, M.D.

Gastrectomy for Ulcer Diathesia—Surgeon, Robert J. Freeark, M.D.

Discussion of Gastric Freezing—R. deWall, M.D., and Foster L. McMillan, M.D.

OPERATING ROOM B

8:00-10:30 a.m.—

Moderator: Louis P. River, M.D.

Surgical Management of Large Ventral Hernia of Abdomen—Surgeon, Manuel E. Lichtenstein, M.D.

Discussion—Amos R. Koontz, M.D., Johns Hopkins Medical School, Baltimore, Maryland

OPERATING ROOM C

8:00-10:30 a.m.—

Moderator: Geza deTakats, M.D.

Surgery for Peripheral Vascular Disease—Surgeon, Robert J. Baker, M.D.

Discussion—Gustav W. Giebelhausen, M.D. and Jack C. Cooley, M.D.

OPERATING ROOM D

8:00-10:30 a.m.—

Moderator: George E. Block, M.D.

Radical Mastectomy for Breast Carcinoma—Surgeon, Frank A. Folk, M.D.

Discussion—Eugene Lutterbeck, M.D.

Radiation for Cancer—Thomas W. Samuels, Jr., M.D.

OPERATING ROOM E

8:00-10:30 a.m.—

Moderator: Kenneth H. Schnepp, M.D.

Vaginal Hysterectomy with Perineal Repair—Surgeon, Walter J. Reich, M.D.

Discussion—Mitchell Nechtow, M.D.

Management of Carcinoma of the Cervix—Donald H. Dexter, M.D.

OPERATING ROOM F

8:00-10:30 a.m.—

Moderator: W. James Gillesby, M.D.

Surgery for Megacolon, Nerve Biopsy—Surgeon, John R. Raffensberger, M.D.

Discussion—Orvar Swenson, M.D., and Paul F. Fox, M.D.

OPERATING ROOM G

8:00-12:00

Moderator: Kenneth Lewis, M.D.

Surgery for Intra-Oral Cancer—Surgeon, Orion H. Stuteville, M.D.

Discussion—Robert L. Schmitz, M.D., and Harry C. Southwick, M.D.

Monday, May 18

SECTION ON SURGERY

Sponsored jointly by Illinois Surgical Society and Illinois State Medical Society

Chairman ..... R. S. Malcolm, M.D., Peoria

Secretary ..... Harold V. Norris, M.D., Jacksonville

LOUIS XVI ROOM

1:30-2:30 p.m.—Panel Discussion: Surgery of the Spleen

Moderator: Robert J. Baker, M.D.

Hematologic Disease—Steven O. Schwartz, M.D.

Intra and Postoperative Management—William R. Requarth, M.D.

Trauma—Manuel E. Lichtenstein, M.D.

2:30-3:30 p.m.—Endocrine Management of Breast Cancer—E. Lee Strohl, M.D.; Henry T. Randall, M.D., Professor of Surgery at Columbia Medical School, Director of Memorial Center for Cancer and Allied Diseases, Sloan-Kettering Institute for Cancer Research, New York, New York

3:30-4:30 p.m.—Panel Discussion: Complications of Cholecystitis

Moderator: Robert J. Freeark, M.D.

Pancreatitis and Its Sequalae—Charles B. Puestow, M.D.

Empyema and Hydrops—Karl A. Meyer, M.D.

Obstruction of the Common Bile Duct—John T. Reynolds, M.D.

ILLINOIS OBSTETRICAL AND GYNECOLOGICAL SOCIETY

9:00 a.m. Monday, May 18

GOLD ROOM 114

9:00 a.m.—Annual Business Meeting

9:30 a.m.—Illinois Maternal Mortality Report—John Rendok, M.D., Springfield

10:00 a.m.—Plasma Pseudocholinesterase as a Clinical Problem—Richard Blankshain, M.D., Oak Park

10:30 a.m.—Case Studies—Two Maternal Deaths—John Rendok, M.D., Springfield

11:30 a.m.—Premature Rupture of Membranes—Roy Kurotsuchi, M.D., Oakbrook

12:00 Noon—Luncheon—Jade Room 103

2:00 p.m.—Infertility, a Family Project—William H. Masters, M.D., Washington University, St. Louis, Mo.

3:00 p.m.—Culdoscopy—John Standard, M.D., Springfield

3:30 p.m.—Ovarion Carcinoma—Mark Wheelock, M.D., Pathologist, Passavant Memorial Hospital

SECTION ON ANESTHESIOLOGY

2:00 p.m. Monday, May 18

FRENCH ROOM 107

Chairman ..... Arthur T. Shima, M.D., Oak Park

2:00 p.m.—Newer Trends in Inhalation Therapy

Moderator: Max S. Sadove, M.D., Head, Department of Anesthesiology, University of Illinois

Relation of Technique of Administration to the Physiologic Effect of I.P.P.B.—Edwin R. Levine, M.D., Director of Inhalation Therapy, Edgewater Hospital, Chicago

Use of Acetylcystine and Corticosteroids by Aerosol—Gordon L. Snider, M.D., Associate Professor of Medicine, Chicago Medical School

Inhalation Therapy in the Pediatric Patient—David Allan, M.D., Director of Anesthesiology, Children's Memorial Hospital and Assistant Professor of Surgery, Northwestern University, Chicago

High Intensity Aerosol Therapy—Albert H. Andrews, Jr., M.D., Clinical Professor of Broncho-Esophagology, University of Illinois

Aerosol Therapy in the Chronic Cystic Fibrotic Child—Ira M. Rosenthal, M.D., Professor of Pediatrics, University of Illinois

A New Adjunct to Aerosol Therapy—Benjamin G. Covino, M.D., Medical Director, Astra Pharmaceutical Products, Inc.

SECTION ON NEUROLOGY AND PSYCHIATRY

In conjunction with
The Chicago Neurological Society
Illinois Psychiatric Society
Central Neurosurgical Society

Chairman ..... Louis Boshes, M.D., Chicago

Secretary ..... Harold E. Himwich, M.D., Galesburg

2:00 p.m. Monday, May 18

CRYSTAL ROOM

I—PSYCHIATRY

Moderator: Donald Oken, M.D., University of

Illinois College of Medicine, Psychosomatic and Psychiatric Institute of Michael Reese Hospital and Medical Center

Participants: Richard D. Chessick, M.D., Northwestern University Medical School, Veteran's Administration Researeh Hospital

Robert Daniels, M.D., University of Chicago School of Medicine

Albert Merritt, M.D., Billings Hospital

Daniel Offer, M.D., University of Illinois College of Medicine, Psychosomatic and Psychiatric Institute of Michael Reese Hospital and Medical Center

Isadore Spinka, M.D., Chicago Medical School, Mount Sinai Hospital

Topics: Addicting and habituating drugs; newer drugs-use and abuse; psychopathic personality; suicide; role of the general practitioner as psychiatrist; "intermediate" psychiatric treatment facilities; "halfway houses"; "day and night" hospitals; childhood and adolescence, normal and abnormal; newer tranquilizers and energizers; psychosomatic problems; newer researches on tension and anxiety; psychological problems in medical and surgical disorders, including the patient with a fatal illness; newer thoughts in geriatrics, etc.

II—NEUROLOGY

Moderator: Louis Boshes, M.D., University of Illinois College of Medicine, Michael Reese Hospital and Medical Center

Participants: Alex J. Arieff, M.D., Northwestern University Medical School, Passavant Memorial Hospital

Maynard M. Cohen, M.D., University of Illinois College of Medicine, Presbyterian-St. Lukes Hospital

Joseph A. Luhan, M.D., Stritch School of Medicine, Loyola University; Loretto Hospital

Robert Y. Moore, M.D., University of Chicago School of Medicine, Albert Merritt Billings Hospital

Topics: Newer aspects in epilepsy; role of the EEG; mental retardation; PKU; role of anticoagulants in cerebrovaseular diseases; newer thoughts in neuromuscular diseases; role of genetics in Mongolism; newer thoughts on headaches; fungus diseases; sarcoidosis; new drugs; management of aphasia; child neurology; neurosyphilis; endocrinological aspects; deficiency diseases; intoxications; electromyography; malformations; etc.

Intermission to Visit Exhibits

III—NEUROSURGERY

Moderator: Paul C. Bucy, M.D., Northwestern University Medical School, Chicago Wesley Memorial Hospital

Participants: Joseph P. Cascino, M.D., Stritch School of Medicine, Loyola University, St. Anne's Hospital

Sean Mullan, M.D., University of Chicago School of Medicine, Albert Merritt Billings Hospital

I. Joshua Spiegel, M.D., Chicago Medical School, Michael Reese Hospital and Medical Center

David C. Voris, M.D., University of Illinois College of Medicine, Mercy Hospital

Topics: Profound hypothermia; cryogenic surgery for tumors and correction of extra pyramidol abnormal movements; miscroscopic surgery; newer diagnostic methods; Brain Scan; depth electroencephalography; echoencephalography; newer approach to the management of cerebrovascular lesions; management of intra and extra-cranial aneurysms; newer treatments for intractable pain; radioisotopes, etc.

Question Period

Tuesday, May 19

SECTION ON DERMATOLOGY

Chairman ..... Samuel M. Bluefarb, M.D., Chicago

Secretary ..... Louis Rubin, M.D., Rockford

OLD CHICAGO ROOM 101 Tuesday, May 19

Dermatological Manifestations of Internal Diseases

9:00-9:30 a.m.—Cutaneous Manifestations of the Anemias—Samuel M. Bluefarb, M.D., Professor of Dermatology, Northwestern University Medical School, Chicago

9:30-10:00 a.m.—Some Skin Aids in Diagnosis of Visceral Diseases, If You Look for Them—Leon Goldman, M.D., Professor of Derma-

tology, University of Cincinnati Medical School, Cincinnati, Ohio

10:00-10:30 a.m.—Cutaneous Manifestations of Collagen Diseases—Louis Rubin, M.D., Professor of Dermatology, University of Illinois College of Medicine

10:30-11:00 a.m.—Intermission to Visit Exhibits

11:00-11:30 a.m.—Cutaneous Manifestations of Vascular Diseases—Frederick Szymanski, M.D., Professor of Dermatology, University of Illinois College of Medicine

11:30-12:00 a.m.—Cutaneous Manifestations of Gastro-Intestinal Diseases—Allan Lorincz, M.D., Professor of Dermatology, University of Chicago Medical School

Tuesday, May 19

SECTION ON ALLERGY

Chairman ..... Charles M. Jenkins, M.D., Chicago

Secretary ..... Arthur H. Rosenblum, M.D., Chicago

LOUIS XVI ROOM

9:00-9:40 a.m.—Role of the Thymus in Immunity—David Talmage, M.D., University of Colorado Medical Center, Pres. Elect, American Academy of Allergy

9:45-10:05 a.m.—Delayed Hypersensitivity—Raymond G. Slavin, M.D., Northwestern University

10:10-10:25 a.m.—Passive Transfer of Delayed Sensitivity—Milton Mosko, M.D., Michael Reese Hospital

10:30-11:00 a.m.—Intermission to Visit Exhibits

11:00-12:00 a.m.—Round Table Discussion Transplantation Immunity. Roy Patterson, M.D., Northwestern University, Department of Allergy, Chairman: Peter Baram, M.D., Michael Reese Hospital, Department of Allergy; Joseph T. Sheridan, M.D., Chicago; Sam Zaltzman, M.D., Michael Reese Hospital, Department of Medicine; David Talmage, M.D.

SECTION ON OBSTETRICS AND GYNECOLOGY

Chairman .... Donald M. Fahrenbach, M.D., Chicago

Secretary ..... Paul A. Raber, M.D., Decatur

GOLD ROOM 114 Tuesday, May 19

9:00 a.m.—A Challenge—The Sex Problem—William H. Curtis, M.D.

9:30 a.m.—Caesarian Section—15 years Experience—Thomas R. Wilson, M.D., and Joseph A. Stephens, M.D., Carle Clinic, Urbana

10:00-10:45 a.m.—Intermission to Visit Exhibits

10:45 a.m.—Hormonal Control of the Menopause and Thereafter—William H. Masters, M.D., Department of Obstetrics and Gynecology, Washington University, St. Louis, Missouri

11:30 a.m.—Vaginal Vault Extension of Carcinoma In-Situ—John H. Isaccs, M.D., Chicago

ILLINOIS PHYSICIANS' ASSOCIATION

Chairman ..... Werner Tuter, M.D., Elgin

JADE ROOM 103 Tuesday, May 19

10:00 a.m.—The Educational Program of the Illinois Mental Health Department—Robert C. Drye, M.D., Director of Education, Illinois Department of Mental Health

SECTION ON PUBLIC HEALTH

Chairman ..... John B. Hall, M.D., Chicago

Secretary ..... Charles A. Lang, M.D., Wheaton

2:00-5:00 p.m. Tuesday, May 19

GOLD ROOM

The Role of the Practicing Physician in the Development of Community Health Services—Leon J. Taubenhaus, Director of Public Health, Brookline, Mass.

SECTION ON PHYSICAL MEDICINE

Chairman ..... Arthur A. Rodriquez, M.D., Chicago.

Secretary ..... E. H. Harris, M.D., Glencoe

OLD CHICAGO ROOM 101 Tuesday, May 19

2:00 p.m.—Ultrasound, Shortwave and Microwave Diathermy in Clinical Practice—J. F. Lehmann, M.D., Professor and Chairman of the Department of PM and R, University of Washington School of Medicine

Total Rehabilitation of the Multiple Injury Patient—M. E. Knapp, M.D., Clinical Professor of PM & R, University of Minnesota Medical School, Director PM & R, Elizabeth Kenny Institute

Therapeutic Electricity in Clinical Practice—G. K. Stillwell, M.D., Consultant in PM & R, Mayo Clinic, Instructor Mayo Fd.

Sponsored by Hoffman-La Roche Laboratories

SECTION ON RADIOLOGY

Chairman ..... R. S. Malcolm, M.D., Peoria

Secretary ..... Frederic D. Lake, M.D., Chicago

CRYSTAL ROOM — Tuesday, May 19

2:00-3:00 p.m.—Early Detection of Strangulation Obstruction of Small Intestine or When in Doubt Use Barium!—Russell Nichols, M.D., Thomas D. Dee Memorial Hospital, Ogden, Utah

3:00-3:30 p.m.—Intermission to Visit Exhibits

3:30-3:45 p.m.—Business Meeting of Section

3:45-5:00 p.m.—Film Interpretation—Donald F. Anderson, M.D., St. Francis Hospital, Peoria
Frank Hussey, Jr., M.D., Lutheran General Hospital, Park Ridge
Carroll R. Markivee, M.D., Galesburg Cottage Hospital, Galesburg
James R. Williams, M.D., University of Chicago Clinics, Chicago

ILLINOIS CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

6:30 p.m. — Tuesday, May 19

CRYSTAL ROOM

An Artificial Heart Inside The Chest—William J. Kolff, M.D., Department of Artificial Organs, Cleveland Clinic, Cleveland, Ohio

MEDICINE AND RELIGION

Committee on Medicine and Religion, ISMS
and
Catholic Physicians' Guild of Chicago

Tuesday, May 19 — 8:00 p.m. — Bal Tabarin

Spiritual Needs of the Sick

Moderator: Harold B. Haley, Jr., M.D., President, Chicago Chapter, Catholic Physicians' Guild

Panel: **The Pastoral Care of Patient Needs**—The Rev. Meredith Thomas, Pastor, First Baptist Church, Mattoon

What Help the Physician Needs From the Chaplain—Paul S. Rhoades, M.D., Professor of Medicine, Northwestern University Medical School

Communication Between Doctor, Patient and Chaplain—The Rev. John Marren, Pastor, Holy Trinity Church, Chicago

An Analysis of Jewish Chaplaincy—Rabbi Irvine M. Melamed, Director of Chaplaincy Services, Chicago Board of Rabbis

OPEN TO ALL PHYSICIANS
AND CLERGYMEN

Wednesday, May 20

SECTION ON PATHOLOGY

Chairman ..... Frederick C. Bauer, M.D., Joliet

Secretary ..... E. H. Harris, M.D., Glencoe

LOUIS XVI ROOM

9:00-12:00 a.m.—Enumeration of Blood Cells; Determination of Hematocrit—Leonard C. Hurley, M.D., Elgin

Measurement of Hemoglobin—James E. Habegger, M.D., Geneva

Preparation and Examination of Stained Blood Smears—Otto C. Brosius, M.D., Decatur and Macon County Hospital, Decatur

Basic Urinalysis; Examination of Urinary Sediment—presentation of film strips, prepared by John B. Fuller, M.D., for Commission on Continuing Education, American Society of Clinical Pathologists

Acute Phase Reactants—Frederick Volini, M.D., West Suburban Hospital Association, Oak Park

"Tubeless" Gastric Analysis by Ion-Exchange Resin Techniques—Donald R. Fox, M.D., Lake Forest Hospital, Lake Forest

Examination of Feces for Occult Blood—Application and Limitations of Available Techniques—Robert W. Woods, M.D., Community Memorial General Hospital, La Grange

Bacteriologic Screening Procedures; Collection of Specimens for Bacteriologic Examinations—Robert W. Wilhoite, M.D., St. Francis Hospital, Evanston

Quality Control in the Physician's Office Laboratory, Essentials and Techniques—Dennis B. Dorsey, M.D., Danville

Evaluation of Laboratories; Programs of the Illinois State Department of Health and of the Committee on Laboratory Evaluation of ISMS—James B. Hartney, M.D., St. Anne's Hospital, Chicago

SECTION ON PEDIATRICS

9:00 a.m. Wednesday, May 20

CRYSTAL ROOM

Chairman . . . . . Richard E. Dukes, M.D., Urbana

Secretary . . . . . E. H. Harris, M.D., Glencoe

9:00-12:00—Measles Vaccine—Saul Krugman, M.D., Professor and Chairman, Department of Pediatrics, New York University School of Medicine

Keystone of Pediatrics—Dwain Walcher, M.D., Professor of Pediatrics, Indiana University Medical School

Malignant Tumors in Children—Joseph Greengard, M.D., Chief of the Department of Pediatrics, Cook County Hospital

Allergic Problems in Children—James B. Corbett, M.D., Pediatric Allergist, Carle Clinic, Urbana

Dr. Greengard is being sponsored by Mead Johnson Laboratories

Dr. Krugman is being sponsored by Merck, Sharpe & Dohme

GENERAL ASSEMBLY

LOUIS XVI ROOM 2:30 p.m.

Drug Programs of the AMA—Hugh H. Hussey, M.D., Director of the AMA's Division of Scientific Activities

CAMP MEMORIAL LECTURE

3:15 p.m.—Man's Eternal Illusions of Health and Sanity—Jules H. Masserman, M.D., Professor and Co-chairman, Department of Psychiatry, Northwestern University School of Medicine

Thursday, May 21

SECTION ON EYE, EAR, NOSE AND THROAT

Chairman . . . . . Burton J. Soboroff, M.D., Chicago

Secretary . . . . . Roland I. Pritikin, M.D., Rockford

GOLD ROOM 114

8:00 a.m.—Tonometric and Tonographic Features of Early Wide Angle Glaucoma—Alex E. Krill, M.D., Chicago

8:15 a.m.—Application of Plastic Surgical Procedures in Eyelid Surgery—George S. Pap, M.D., Rockford

8:30 a.m.—The Psychiatrist and the Eye—H. J. Drell, M.D., Rockford

8:45 a.m.—Psychosomatic Medicine, Otolaryngology and the Ano-erotic Complex—Jay H. Schmidt, M.D., Chicago

9:00 a.m.—Abnormalities of the Peripheral Retina—J. Graham Dobbie, M.D., Chicago

9:15 a.m.—Improved Cryo Surgery of Cataract—John G. Bellows, M.D., Northwestern University and Cook County Hospital

9:30 a.m.—Cough-Headache; Clinical Varieties and Treatment—Bayard T. Horton, M.D., Chief, Headache Clinic, Mayo Clinic, Rochester, Minnesota

10:15 a.m.—Hereditary Constitutional Syndromes of Interest to All Practitioners—Harold F. Falls, M.D., Professor Ophthalmology, University of Michigan, Ann Arbor, Michigan

11:00 a.m.—The Cornea—Charles I. Thomas, M.D., Professor of Ophthalmology, Western Reserve University, Cleveland, Ohio

1:15 p.m.—Indications for Modern Ear Surgery—George R. Farrell, M.D., Rockford

1:30 p.m.—A New Surgical Approach to Entropion—Chester Roe, M.D., Rockford

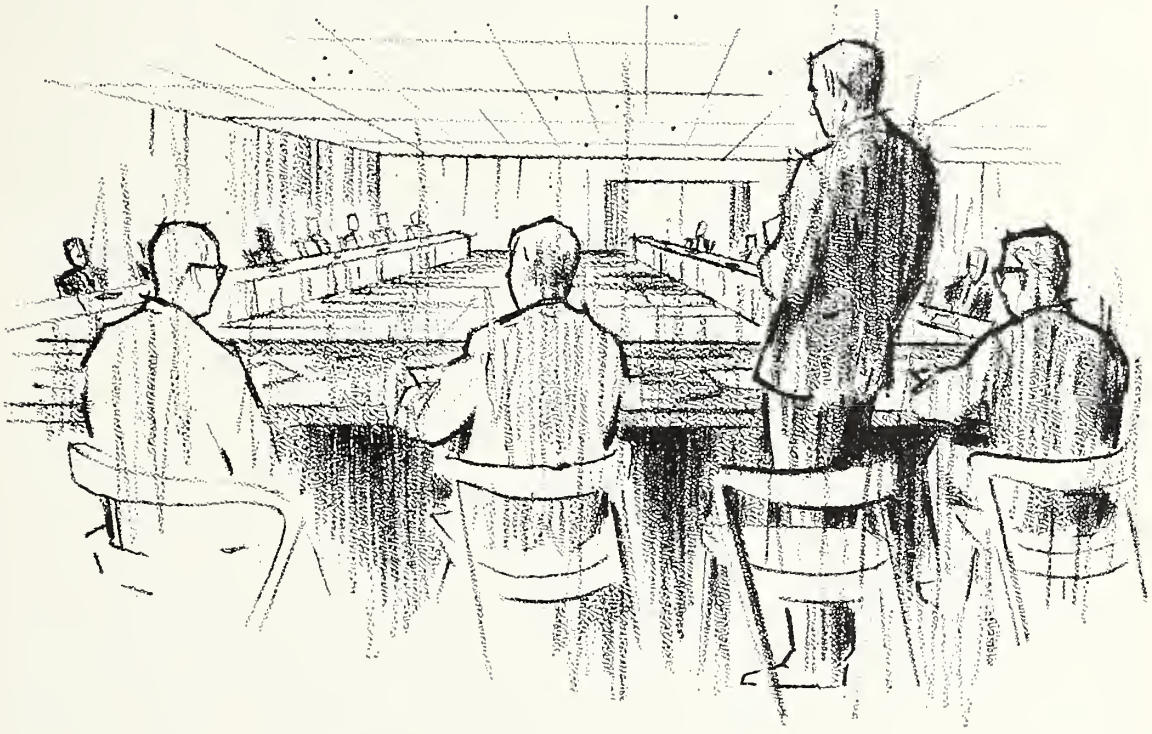
1:45 p.m.—Symptomatic Treatment for Ragweed Hay Fever—Ray F. Beers, Jr., M.D., Rockford

2:00 p.m.—Proptosis Patterns—John W. Henderson, M.D., Chief, Eye Department, Mayo Clinic, Rochester, Minnesota

2:45 p.m.—New Thoughts on Uveitis—G. Victor Simpson, M.D., Consultant, Walter Reed Hospital, Surgeon, Washington Hospital Center

3:30 p.m.—Business Meeting

ISMS Annual Reports . . .



. . . Officers and Trustees

REPORT OF THE PRESIDENT

Fellow Delegates: As I see it, the basic purpose of a professional society like ours is to aid and support the ideals of our members. I appreciate the opportunity of furnishing some leadership to the great group of dedicated men and women who comprise the medical profession in Illinois. As you know, Illinois medicine is made up of teachers, researchers, administrators, and practitioners in all the rooms of the great house of medicine.

I have enjoyed the opportunity and responsibility of listening to many persons who really believed they had "the answer" to one or another of the problems that confront our profession and our organization. Differences in emphasis are to be expected The correlation of ideas and the determination of what is the greatest good for the greatest number will always be the main problem of the President of any professional organization.

The details of the Society's activities in a variety of specific areas will be found in other reports in this handbook. The other officers, committee chairmen, and committee members will have submitted detailed reports of their actvities.

Medical Education

Medicine, of course, begins with the production of new physicians. The increasing number of full-time medical teachers disturbs some clinical practitioners. However, the quality of the knowledgeable new M.D. appears to justify this number of teachers.

The medical practice act in Illinois provides, I believe, many different ways of training doctors after they have graduated from medical school. The internship is not even mentioned in our Act. The Act merely requires one year of in-hospital training. This makes for maximal flexibility in training.

Some critics say the 80 per cent specialty training choice, and the 20 per cent general medical training choice made by current students does not represent the public or the professional needs of our society. This observation may or may not be true.

The Doctor's Conservatism

The changing patterns of medical practice are carefully appraised by a truly conservative profession. This is as it should be. Doctors are required to be conservative because they deal with the persons' most valuable assets—his life, and his health.

There is danger in too much immature experimentation with people's health care, diagnosticwise, treatmentwise, or dollarwise. History teaches us that it is wiser to evolve something better than it is to destroy both good and bad by revolutionary acts. This historical lesson is difficult for some segments of our society to grasp. The so-called "intellectuals," some labor leaders, and some politicians dislike the evolutionary approach to medical care problems. Most of us in the house of medicine have found that our greatest progress has come by gradual degrees—not by untried "leaps forward."

Medical Progress in Illinois

The medical profession's care for the health needs of our citizens this year has brought a gradual, but obviously improved, health status for all. For example, the doctor's leadership in encouraging the public to accept poliomyelitis vaccine on a mass basis has been most rewarding. Illinois had the fewest polio cases in its history during 1963. The increasing public acceptance of other immunization programs—either by groups, or through patient selection of an individual practitioner—has also been most rewarding. No one can actually measure the savings in lives, suffering or dollars that these programs have achieved.

Progress in tuberculosis therapy has reached a point where there is now serious doubt regarding the public need to maintain most of our County operated tuberculosis sanataria. The Illinois Department of Health, the Hospital Licensing Board, members of the medical profession in each county, and an adequately informed public must take a long hard look at the significance of this disease. Dollarwise and carewise the state tuberculosis sanataria are capable of doing a better care job than are the isolated, inadequately staffed (for thorough treatment), county sanataria.

"County Seat" Medical Centers

More and more the active care of the sick citizen is being concentrated near the community hospitals of our state. Fewer doctors are going into the city as solo practitioners. More formal groups, more partnership, and more loose co-operatives of physicians are helping to develop more "county seat" medicine. From this development, it appears to me, the 100-bed or less hospital is becoming a more expensive and inadequate health center. To my mind, the public and the profession have a tremendous stake in our health center developments. I hope the profession will carefully consider not only the initial cost but also the upkeep and adequacy of any proposed health facility established anywhere in Illinois.

Medical Insurance

More of our citizens continue to acquire insurance protection against the cost of illness. For example, the total health insurance benefits paid—including loss of time—was $560 million to Illinois inhabitants in 1961. Blue Cross and Blue Shield paid $166 million of this amount. The insurance carriers paid the remainder.

In Illinois, nine million persons had hospital insurance, eight million had surgical expense insurance, and six million had medical expense insurance.

During 1962 major medical expense insurance volume increased by 23 per cent in the number of people covered. The individuals who purchased major medical protection increased by 42 per cent in 1962. Such phenomenal increases in third party payments means more paper work for the individual doctor and his secretary. The people who assist physicians in this work have done a superior job.

The district and state grievance committees and the insurance committees will have a greater arbitration hearing case load to dispose of. I consider this an inevitable part and price for the profession to pay for an improving non-governmental method of paying for health care and needs.

Costs of Hospital Care

In order to make our voluntary "choice of the market place" system work, all phases of our health team must carefully weigh demands on our people's health dollars. For example, our doctors have been under much pressure to hospitalize insured patients. Despite all of the new services performed for patients in today's hospital, our physicians have kept the patient's stay down extremely well. Timewise, patients spend only 12 per cent more days in the hospital now than they did 20 years ago.

As doctors, however, we must explain hospital costs to our patients on a realistic basis. They must be given factual information about just what hospital costs represent. Twenty years ago, for example, there were one and a half hospital employees for each hospitalized patient. Today there are two and a half employees per patient. Hospital wages 20 years ago represented 50 per cent of hospital costs. Today, those same wages total 66 per cent of hospital costs. On a nationwide basis, the hospital payroll 20 years ago was $260 million per year. In 1963 this figure was $4.25 *billion*. The 40-hour week, new techniques and technicians un-

known 20 years ago, and a general improved quality of medical service are all factors which contribute to rising hospital costs. These facts—and the facts of the patient's unprecedented rewards and benefits—must be explained to the public.

Public Aid

In the area of public monies spent for health services and care, our doctors and our state officials have done a consistently improving job of caring for those in need. Our public aid advisory group's performance in the counties and at the state level is the envy of most other state medical societies. The dedicated doctors who serve in these programs cannot please everybody. But their efforts and the reasonable adequacy of state dollars has produced an excellent overall health result for our citizens.

Kerr-Mills implementation in Illinois has improved each month as experience develops. We have learned that the benefits for the truly needy can be improved without necessarily financially bankrupting the state.

The Population Explosion Problem

At present, the toughest situation in the public money picture is in the Aid to Dependent Children area. The exploding reproduction rate of this group —the progency of which are frequently illegitimate —is such that if it is not alleviated it threatens to destroy our way of life and our standards of living. If the present birth rates continue at their present pace, there will be no apparent solutions for problems such as those concerned with traffic, air pollution, diminished water supply, polluted water supply, sanitation, education, and housing.

The very informed people on population affairs suggest that the 10-year-old girl of today must learn that she will probably be condemned for committing an act of moral and social irresponsibility if she has more than three children.

I predict that the failure of doctors and other responsible individuals to transmit the population control message to the publicly supported groups in our society will, in a very few years, result in a strong public reaction. The voter demand might well become so powerful that national sterilization and abortion laws will become necessary for survival. In that event, the groups now opposed to compulsory birth requirements for ADC and relief people would soon accept the measures they are now against as better than national sterilization or abortion laws. In one way or another, this population explosion problems must be solved. Our state and our country cannot afford to have "relief living" become a profession.

Transmitting the Profession's Views

From personal observation, I would say that membership and activity in your own Chamber of Commerce is one of the best ways for the medical profession to make its views known and felt. The U.S. Chamber of Commerce does a superb job in Washington. Your Illinois Chamber of Commerce performs very effectively in Springfield. The backbone of their performances is the same as that of your state medical society's performance—good city and county activity.

In today's world, an effective organization of experts in various fields is necessary for success. Your ISMS has an effective, able, and dedicated group of employees. It is true that they are expensive, and that the dues you pay to your Society are high. But the quality of jobs done for our citizens and for Society members has never been equalled.

Our Illinois physicians have been and continue to be the most responsible group in the country, so far as their contributions to medical education goes. One of my proud moments this year took place when I presented the AMA-ERF check representing $185,000 of your money. This award made many small but good things possible for the students and faculties of our five Illinois medical schools. To me, this represented the finest, most effective, and most beneficial $20 any of us will spend in another calendar year.

Acknowledgements

May I conclude by thanking some folks personally. Thanks to Governor Kerner for his reasonableness in health matters—both from the public and from the profession's viewpoint. Thanks to Dr. Yoder for managing a fine Department of Health. And thanks to Dr. Visotsky for filling well the large shoes of Dr. Gerty in our State's Mental Health Affairs.

Thanks particularly to you delegates who labor yearly to bring in, and who distill into workable fashion, all of the diverse ideas presented by our member doctors. Thanks to the trustees of your Society for their advice, tolerance, and efforts in both your and my behalf. Thanks also to the doctors wives for their dedication and patience in the cause of good health—not only for the doctor himself, but for his patients as well. Thanks to the 2,000 Illinois doctors who serve on county, state, and AMA councils and committees, without whose efforts there would be no professional organization. Thanks to our 8,000 other members who pay their dues, go about their work, grouse about the Society and what its officers do—yet perform the best possible health care job for the people of Illinois.

Lastly, thanks to three special persons. First, to my most able and understanding wife. Second, to my partner, Dr. Alan Taylor. Without his willingness to "watch the store" and care for (to me) the greatest group of people in the world—"our patients"—I would have been unable to devote this year to serving you as President of your Society. Finally, thanks to Irma, who typed hundreds of letters over and above the call of duty.

Harlan English, *President*

PRESIDENT-ELECT

The duties of the President-Elect vary tremendously, ranging from membership on committees to official representation of the Society at various functions—dinners, luncheons, conferences, seminars, etc.—which cannot be attended by the President. The reports of the various committees appear elsewhere in this report.

Your President-Elect has been very much interested in making available to the general public the policies of the Illinois State Medical Society in printed form. When these policies are widely distributed and understood, we will no longer have to combat the allegation that medicine "is against everything."

The policies that have been laid down by our state organization speak well for the broad interest of the physicians in the health of their communities and their state, which in turn is reflected in the high standards of medical, hospital, and community public health programs which have been attained in the State of Illinois.

The responsibility of the physician as a community leader and citizen has always been recognized for good government, good education, good hospital care, and good medical care begin with the people at the local level.

If we are to fight the invasion of the Federal government into state and local medical programs we must all assume individual responsibility for new leadership in providing the best program medicine has to offer at the local level.

Edward A. Piszczek

FIRST VICE PRESIDENT

The activities of the office of Vice-President are limited and I have no future plans.

I have attended the quarterly meeting except for the July meeting.

I attended the dedication of the new medical center in Sheridan, Illinois, Saturday, January 18th.

Charles Allison, *First Vice-President*

SECOND VICE PRESIDENT

Report not available at publication time. Please check handbook index for late reports.

REPORT OF SECRETARY-TREASURER

During the past year, I have had numerous opportunities to work with the staff of the Illinois State Medical Society in the development of many special programs and meetings. It has always been extremely rewarding to see the members of our staff grasp the needs of each program and contribute so much to the success of our endeavors. Dedicated assistance such as this, especially when it means many hours of overtime, represents the difference between the basic program that can be provided by actively-practicing physicians working alone and the superior coverage that is provided by a highly-professional office staff. It is my hope that each of our members will take the opportunity during any trip to Chicago to visit our office at 360 North Michigan Avenue. He will learn, for himself, about the specific daily activities of each of our staff members. I am sure that no member would question the value obtained from his annual membership dues if he would only take the time to see for himself exactly "where the money goes."

House of Delegates Minutes

A complete stenographic record of the most recent House of Delegates session is available to any interested member of the Society upon request of the Secretary-Treasurer or the Executive Administrator.

In order to make the major actions of the House immediately known to all members of the Society, a resume was mailed to each delegate on May 17, 1963. This enabled him to report promptly to his Society. An abstract of the 1963 minutes was presented in the June, 1963, issue of the *Illinois Medical Journal*. This abstract, containing all actions of the House of Delegates, will be provided to each member of the 1964 House of Delegates to be acted upon as the official minutes of the 1963 meeting.

Secretaries' Conference

The 1964 Secretaries' Conference—a meeting of county society secretaries and other interested county officers, especially the president-elects—will be held on April 12, 1964, at the St. Nicholas Hotel in Springfield.

This year's conference, originally planned for October, 1963, was moved to the spring, 1964. This was done to avoid a conflict with several other programs and activities being presented in the fall and early winter. A spring presentation will also enable us to provide each Secretary with valuable information and background concerning the annual convention of the House of Delegates. Thus the delegates from each county will be able to attend the Annual Convention with a more complete understanding of the actions to come before the House.

The program for this year's conference will feature round-table sessions. Each county society will be provided with a forum to present its viewpoints on the variety of matters that are of common concern to each county.

Billing Procedures

As mentioned in my last year's report to the House of Delegates, a new method of billing, collecting and reporting membership dues has been developed for use during the Society's fiscal year 1964. This new method provides a receipt for each member, as well as a record of the payment for the county medical society. The forms have been pre-addressed from our membership mailing list,

so that the county society secretary may be freed from this burdensome task. We will attempt to continue our efforts to reduce the work-load required of the county secretary in the transmittal of necessary membership information.

The AMA has notified the State office that—beginning with January, 1965—it must provide an annual designation by each physician of the desired AMA specialty journal. Along with the designation of the medical school to receive credit for the $20 AMA-ERF dues allocation, this becomes a formidable and costly task. It is my hope that we will be able to develop a permanent IBM record of these items, eliminating the time and expense needed to request our members to provide the same information each year.

I would again offer a recommendation made (originally in 1963) which would enable the State office to maintain a currently correct listing of county society officers and delegates. I would like to recommend that the Constitution and Bylaws be amended to require uniform election dates of such individuals. I would suggest, for example, that the elections be held in mid-year, and that the officers-elect take office on January 1. The fall period would provide an opportunity for the State office to prepare correct listings for the ensuing year.

Communication With Members

Since the last meeting of the House of Delegates, we have sought to improve the awareness in each county medical society of the State Medical Society's actions. For this reason we have begun the practice of mailing substantial abstracts of each Board of Trustees meeting to each county medical society and to our AMA delegates and alternates. This mailing is in addition to the abstracts of Board and House of Delegates minutes that appear in the *Illinois Medical Journal.* Thus every member of this Society can now have immediate knowledge of all activities of his State Medical Society.

The *Illinois Medical Journal* monthly news features, such as the *Pulse, Legislative Listening Post* and *As I See It From 360* are planned and prepared with the needs and desires of each ISMS member in mind. I strongly recommend a keen review of these features each month by our members. I further hope that we will be receiving suggestions for new and expanded coverage for the future.

The Illinois physician may certainly consider himself to be the best-informed in the country about the affairs of his State Medical Society. Any member is free to call upon our Executive Administrator or myself for additional minutes, financial reports, or any other documents we might have on hand that contain the information he requires or desires.

Membership

A statistical analysis of our membership on December 31, 1963, is shown below. Additional statistical data is provided in the report of the Membership Committee. Our efforts towards the development of new members from the ranks of physicians who are not in private practice have rewarded us principally with the knowledge that this is no easy task, nor is it one that can be solved with less than intensive effort. It is my hope that the Society will recognize the need for all physicians to unite with their colleagues in all fields of medical endeavor, so that we may bring many of the desired advancements of the future to fruition in our own time.

MEMBERSHIP STATISTICS

Membership as of January 1, 1963		10,101
New members	429	
Reinstatements	59	
Total added		488
		10,589
Dropped during the year:		
Died	176	
Moved from State	60	
Resigned	6	
Nonpayment	202	
Total dropped		444
Membership as of January 1, 1964		10,145
Regular	9,097	
Residents	223	
Service	13	
Emeritus	467	
Retired	328	
Hardship	17	
Total	10,145	

1963 Budget

In 1963, the annual budget was revised downward, effective July 1, to the net extent of $7,300. Estimated *Journal* advertising again fell short. Various divisional budgets were revised to allow for this decrease in anticipated income. The annual *Journal* printing budget was reduced by $8,300 to almost totally offset the $10,000 reduction in budgeted income.

Journal advertising, reprint, and subscription sales failed to meet production and promotion costs by $11,670 in 1961; by $17,900 in 1962; and by approximately $22,255 in 1963. This gradually worsening financial situation emphasizes—in dollars and cents—the serious adverse effect that bad national publicity and legislation related to the drug industry have had on state and local medical publications.

If, however, we apply to *Journal* income the constitutionally provided sum of one-half the regular subscription price for each subscription that is provided to our members as a membership benefit, then we have more than covered this sales deficit.

This the Board of Trustees has done. I might add, however, that the practice of reporting this membership dues allocation as income is a practice that is followed by many state medical journals, in order that they might present their financial results in as favorable a light as possible. In Illinois, we prefer to have our *Journal* break even on its advertising revenue.

For the complete fiscal years of 1961, 1962 and 1963, the Society has been fortunate enough to accumulate surpluses totaling $49,000. For the fiscal year 1964, the Board has approved a budget showing a net *deficit* of $32,750. The necessity for this action was caused by current major program improvements within the Society's normal activities. For several years now, we have attempted to maintain our Educational and Research Foundation and also a Public Affairs program—items of great consequence to Illinois medical progress—with a very restricted budget. We have also refrained from creating certain necessary employee-service retirement reserves and a special new-member issue of the *Illinois Medical Journal* containing information of a permanent reference nature concerning practice in Illinois.

It was recently decided that our excellent finan-

ILLINOIS STATE MEDICAL SOCIETY
POSITION STATEMENT—DECEMBER 31, 1963

	Total	General Fund	Benevolence Fund	Equipment Replacement Fund	Student Loan Fund	Property Fund
ASSETS						
Cash	$142,466.45	127,047.58	10,105.08	4,095.47	1,198.32	
Receivables	3,983.37	2,733.13	1,250.24			
Investments, at cost	239,153.36	92,660.08	140,493.28		6,000.00	
Student loans	85,121.50				85,121.50	
Prepayments and advances	6,976.54	6,976.54				
Office furniture and fixtures	60,723.17					60,723.17
Total Assets	$538,404.39	229,417.33	151,848.60	4,095.47	92,319.82	60,723.17
LIABILITIES AND FUND BALANCES						
Payables	$ 22,348.58	22,348.58				
Accured expenses	2,000.00	2,000.00				
Deferred income	625.00	625.00				
Fund Balances	513,430.81	204,443.75	151,848.60	4,095.47	92,319.82	60,723.17
Total Liabilities and Fund Balances	$538,404.39	229,417.33	151,848.60	4,095.47	92,319.82	60,723.17

INCOME STATEMENT—GENERAL FUND—YEAR ENDED DECEMBER 31, 1963

INCOME		EXPENSES	
Membership dues—		Board	$ 35,543.31
Basic dues—$80 per member	$741,415.00	ISMS and AMA Meetings	53,207.57
Less allocations:		Administration	73,402.22
American Medical Association—Education & Research Foundation $20 per member	185,270.00	Business Office	58,635.52
		Springfield Office	34,248.90
Benevolence Fund— $2 per member	18,527.00*	Public Relations and Field Services Division	80,740.22
Total allocations	203,797.00	Legislation and Economics Division	105,244.19
Net membership dues	537,610.00	Publications and Scientific Activities Division	39,637.70
Illinois Medical Journal	79,875.86	Illinois Medical Journal	102,130.21
Annual Convention exhibits	14,475.00	Non-departmental	55,299.22
Interest & dividends	17,160.30	Total Expenses	638,089.06
All other	10,448.90	Excess of Income over Expenses	$ 21,489.00
Total Income	$659,578.06		

*1963 assistance payments totaled $31,650.45

cial results of the past three years fully justified advancement of these worthwhile projects to a stage of final development. The necessary financial support for them was included in the plans. There was *no* recommendation for a dues increase for 1964.

There is no assurance that the net deficit for 1964, if indeed a deficit does develop, will necessarily total $32,750. Your officers, committee chairmen, and staff will certainly exert every effort to conserve finances and obtain every economy of operation that is possible. However, we cannot allow medicine to lose its rightful progress and freedom for the lack of support represented by the necessary dollars.

Investments of Reserves

Our basic investment policies and program have not changed measurably in the past year. At the end of 1963, the General Fund reserves totaled approximately $204,000. Of this amount, 18 per cent was invested in U.S. Government bonds, 55 per cent was in bank savings accounts returning 3½-4 per cent interest, and 27 per cent was in common stocks.

The Benevolence Fund reserves have also been included in this investment program. They totaled approximately $152,000 on December 31, 1963. Of this, 52 per cent was in U.S. Government bonds, 9 per cent in bank savings accounts, and 39 per cent in common stocks.

This entire investment program is under the supervision of the Trust Department of the Continental Illinois National Bank of Chicago. All investments are made on recommendation by the bank, after review and approval by the Finance Committee of the Board of Trustees. Custody of all securities is maintained by the bank, and monthly reports of principal and income are made.

Income from long-term investments and short-term cash surpluses rose by $2,300 in 1963 to a total of $17,160. Investment return from temporary cash surpluses is subject to variations in the changing national money-market and also to changes in the timing of the Society's cash requirements. We constantly seek, however, to maximize the return we obtain from our investments, consistent with minimization of risk of loss.

Financial Statements for 1963

Condensed financial statements are presented here for the benefit of the entire membership. Our complete audit report for the year ended December 31, 1963, will be provided to each member of the House of Delegates. Copies of our 1964 operating budget, as approved by the Board, will be made available to the appropriate reference committee for its consideration and comment. Doctor Montgomery, Chairman of the Finance Committee; Mr. Richards, our Executive Administrator; Mr. King, Director of the Division of Business Services; and myself will be available at the reference committee hearing to assist it in any way possible in its deliberations.

Jacob E. Reisch

SPEAKER AND VICE SPEAKER

In the estimation of your Speaker and Vice Speaker, the affairs of the House of Delegates ran smoothly in 1963. We wish to express our appreciation for the excellent co-operation during the three sessions.

Although there was considerable discussion from the floor last year, most of the controversial matters were thoroughly covered in the Reference Committee sessions on Monday. The function of the Reference Committee is to expedite the work of the House, give all members of the medical profession (as well as delegates to the House) an opportunity to express opinions, suggest solutions, and to clear the House floor of unnecessary debate. We hope that no delegate will needlessly take up the time of the entire House to discuss matters which fundamentally should have been aired at committee hearings. We assure you, however, that every consideration will be given to opinions expressed by any member of the House. Debate, of course, will be limited, as determined by the Committee on Rules and Order of Business and subsequently approved by House action. The speaker will rule in these matters only when necessary.

Again this year, we have received the suggestion that in order for resolutions to be considered they should be in the hands of the headquarters office for processing weeks ahead of the meeting. Most resolutions could be so handled. They could be published in the April issue of the Illinois Medical Journal, then discussed before the meetings of the various county societies prior to attendance at the annual convention. Delegates could be instructed by majority vote at the county level. They could then reflect the thinking of their confreres when their votes are cast at the sessions. However, we must protect the right and privilege of every delegate to offer for consideration whatever item of business may be properly brought before the House. Your speakers feel that the only limitation that should be placed upon the presentation of resolutions, is the ability of the headquarters staff to prepare sufficient numbers of copies for distribution at the opening session of the House. In the meantime, we urge you to set down all resolutions in proper form, then to submit them to the ISMS office at 360 North Michigan Avenue, Chicago, Illinois, for processing and publication.

Should any county medical society or individual member of the House require assistance in preparing a resolution, the society or the person should first submit it in an outline form which clearly indicates the meaning to be conveyed. The headquarters office may then be asked to put the material in formal order. After the resolution has been prepared, it will be sent to you for approval

prior to its official publication or listing.

The opening meeting of the House will run more smoothly if members who have resolutions to introduce will be prepared to present the "resolved" portion when pertinent items come up for consideration.

Again this year the packet distributed at the opening meeting of the House will contain instruction sheets on parliamentary procedure. A complete table, or chart, explaining how the type of motion to be presented is classified—and the paragraph and page in *Roberts* where information can be secured instantly—will also be included.

The headquarters office will mail you a general summary of *Your Role—as a delegate* which may give you additional assistance and information.

Please feel free to contact your speakers at any time. We will be personally interested in assisting you in any way we can.

Walter C. Bornemeier, *Speaker*
E. W. Cannady, *Vice Speaker*

TRUSTEE REPORTS

FIRST DISTRICT

In an attempt to disseminate information concerning state medical society policy and activities, the first district initiated district delegate meetings in conjunction with meetings of several of the county medical societies. In a session before the general meetings, the delegates and trustee met to discuss matters concerning the various problems. This serves to inform the delegates about Board of Trustee actions, and to emphasize the report as published in the Illinois Medical Journal. It also acquaints the trustee with the activities of the societies in his district.

The delegates from the first district plan to initiate, by resolution, a change in the definition of "emeritus" membership. It is felt that one of the qualifications should be retirement from any active practice.

In my report to the House last year, I dealt rather fully with the lack of individual member response to any united effort on behalf of medical affairs. It is gratifying to note that more physicians are responding and are working for the cause of medicine in all facets of our organization's program.

A majority of the counties have held or will have held meetings specifically concerned with public affairs and organizational problems. Their scientific programs are sustained, in a great measure, by the Postgraduate Medical Education and Scientific Service Committee from the State Medical Society office. All of the component societies, either individually or by district cooperation, have held meetings serviced by headquarters staff.

The concentrated efforts to keep the delegates and the trustee in close cooperation, and to correlate the affairs of the district with those of the headquarters staff, should be fruitful. The delegates should become a more important link in the chain of communication between the county medical society, the House of Delegates, and the Society as a whole. The delegate occupies a key position which the First Trustee District will continue to utilize more and more in the year to come.

Carl E. Clark, *Trustee*

SECOND DISTRICT

The county medical societies of the Second District have enjoyed a year of activity through the competent leadership of their officers and committees. At the time of this report there are no resolutions from the county societies for presentation to the House of Delegates at the annual meeting in May 1964.

The professional membership of the district has remained practically the same as that of the preceeding year.

It has not been necessary to convene the Ethical Relations Committee, the Grievance Committee or the Prepayment Plans Committee of the district during the past year.

The county societies have held periodic scientific meetings with speakers chosen either from the scientific programs presented by the Scientific Service Committee or from the speakers supplied by foundation programs.

In October, 1963, a district meeting was held. The program was conducted by the Scientific Service Committee and the administrative staff of the Illinois State Medical Society. Meetings such as this present much factual information and should be better attended.

Lee and Whiteside County Medical Societies held a combined meeting with the Life Underwriters Association of these respective counties in March of this year. The program was presented by representatives of the Illinois State Medical Society. Jerome Stocker, M.D. of Elmhurst, discussed King-Anderson legislation, and Mr. Walter Livingston of Staff Headquarters discussed Kerr-Mills in Illinois. This was a very informative program and would be well worth while setting up in other areas.

Activities in "Operation Hometown" and Public Affairs meetings have varied from slight to intense in the District. Every doctor should realize that the medical profession cannot interest others in extremely important socio-economic problems unless the individual doctor acquaints himself with pertinent facts and takes positive action.

Community General Hospital of Sterling, Illinois is affiliated with a nursing program of Northern Illinois University and with a licensed practical

nursing program of Dixon State Hospital, and a licensed practical nursing program of Sterling Township High School.

Your trustee presented two fifty-years-in-practice certificates during the past year. Your trustee is an ex-officio member of the Committee on Medical Service, and one of the chairmen for "Operation Hometown."

I wish to express my gratitude to the officers and members of the county societies for the cooperation and the courtesies extended to me. It has been a privilege to work with the officers and trustees, and committee members of the Illinois State Medical Society. I wish to thank the headquarters staff in both the Chicago and the Springfield offices for the help and cooperation given to me.

Ralph N. Redmond

THIRD DISTRICT

Report not available at publication time. Please check handbook index for late reports.

FOURTH DISTRICT

The Fourth District of the Illinois State Medical Society is comprised of the County Societies of Fulton, Hancock, Henderson, Henry-Stark, Knox, Mercer, McDonough, Peoria, Rock Island, Schuyler and Warren. During the year the component County Societies have continued actively and have cooperated in the projects sponsored by the State Society.

Your Trustee attended all trustee meetings held during the year in Chicago. All sessions of the Annual Illinois State Society Meeting held in May were also attended. He served on the Membership Committee and on the Policy Committee.

Your Trustee also attended the AMA meeting held in Atlantic City in June, and the fall meeting held in Portland, Oregon, in early December.

Your trustee officially represented the State Society at the funeral of Mrs. E. P. Coleman in Canton August 24, 1963.

Your trustee attended the Association of Commerce Meeting for the State of Illinois held in Chicago last fall.

50-Year pins were presented to Dr. Coleman of Canton during the last Annual Meeting, and to Drs. Vonachen, Dimond, Haas and Cooper Sr. of Peoria, and Dr. Verne Corman of Rushville.

Your Trustee also represented the Society at an Illinois State Chamber of Commerce Meeting held in Peoria. He also attended a meeting with AMA President Dr. Annis, at a luncheon in Peoria, and a meeting in Bloomington given at Illinois Weslyan University.

A meeting of your Trustee and the officers and delegates of various component societies was held in Galesburg April 13, 1963. At this program Mr. Richards talked on the functions of the Society. The meeting was addressed by Dr. Harlan English. Another such meeting is planned for this April.

Your trustee attended the meeting given by the Henry County Medical Society in conjunction with the State Society at a dinner given in honor of Dr. C. Paul White, former president of the Illinois State Medical Society and delegate to the AMA, on November 6, 1963.

The various County Societies have been or are on schedule for an annual visit during the year.

Nominations from the membership of the District have been made for the formation of the various committees as they have occurred.

The Constitutional Committees of the District, namely Grievance, Third Party Plans, and Ethical Relations were not convened as no occasion arose which the component societies could not resolve.

Your Trustee wishes to express his appreciation for the cooperation of the membership of the county societies comprising this district. He also wishes to include in that expression of appreciation the State Society Officers and the Staff who give generously of their time and ability to get the job done.

Fred C. Endres, *Trustee Fourth District*

FIFTH DISTRICT

The undersigned Trustee was elected to fill the unexpired term of Dr. Jacob E. Reisch in 1963.

Professional organization in the eight counties concerned seems to be healthy. Most of the Societies conduct monthly meetings with appropriate scientific programs. Committees and Officers function smoothly. The Sangamon County Bulletin continues to be the outstanding Central Illinois Professional publication.

Your Trustee has visited meetings in Sangamon, Montgomery, Logan and McLean Counties. The Postgraduate Assembly hosted by Tazewell County will be attended on March 19, 1964.

Organized medicine takes pride in the annual exhibit at the Illinois State Fair under the guidance of Dr. Reisch, our State Secretary.

One of the most important events to occur in our District was the conclave of our delegates on November 12, 1963 in Springfield. Ten delegates registered. Addresses were delivered by Mr. Richards and by Mr. Widmer. All concluded that such meetings should be scheduled more frequently.

At the following meeting of the Sangamon County Society the District Delegates presented Dr. Reisch with a handsome engraved plaque in recognition of his years of valued service as Fifth District Councilor and Trustee.

District Committees reported no problems thus testifying to the wisdom and efficiency of County Society Committee efforts.

Lee N. Hamm, *Trustee*

SIXTH DISTRICT

The constituent medical societies of the Sixth District operated efficiently as usual. For this the officers should be commended. I am grateful to the physicians of the county medical societies for their cooperation in all the procedures and programs which have been initiated.

Membership in this district remains about the same. It is probable that we will gain some new members in the Morgan County area. Here a number of the physicians who practice in the State Hospital have not previously been licensed because of citizenship requirements.

District committees have not been called upon to act officially.

Most of our societies initiated Oral Polio Vaccine Programs. These were successful. The programs were carried out in conjunction with neighboring counties within and without the state. Morgan County was host to a successful *Conference on Nutrition and the Heart* on February 27, 1964. The Madison County Medical Society will host the district meeting in early April. The Women's Auxiliary is active in three of our societies. We are hoping that a fourth will be activated this year.

Congressman Findley (20th District) is actively fighting King-Anderson type legislation. To help in this campaign, he has selected his own committee of physicians.

Your trustee has attended all meetings of the Board.

There have been no Fifty Year Awards to present.

Once again, I want to thank the officers and members of the county societies for their courtesies, their hospitality, and their continued cooperation and helpful advice. My appreciation is also extended to the officers and trustees of the Illinois State Medical Society, to the Executive Administrator, and to his staff in Chicago.

Newton DuPuy, *Trustee*

SEVENTH DISTRICT

The Seventh District has added nine members in the Macon County Medical Society, three members in the Fayette County Medical Society, and one in the Effingham County Medical Society. Of this total, five physicians qualified for provisional membership, having made declaration of intention to become citizens of the United States.

Activities of District Committees

There has been no call for a meeting of the Ethical Relations Committee.

The Grievance Committee was called into action twice during the past year. The Clay and Fayette County Medical Societies were involved. The Grievance Committee consisted of Drs. William Sargent (Effingham), Boyd E. McCracken (Greenville), and Edgar W. Weir (Chairman of Atwood). They met five times. This Committee was extremely thorough in its investigation. The solution in each case was most gratifying.

There was no formal call during the year of the Prepayment Plans Committee.

Outstanding Activities Within Various County Medical Societies

Two well publicized public relations projects were carried on in the Seventh District. The Diabetes Dry Pack program was well received, as was the Disaster Medical Program.

The Macon County Bar Association hosted the Macon County Medical Society a an interprofessional meeting at which the combined Medico-Legal Committee reviewed the Medico-Legal Code.

The Bond County Medical Society has requested Postgraduate Medical Education services from Headquarters for April of this year.

As reported one year ago, all of the component Societies of the Seventh District are staffed on a voluntary basis. An assistant executive secretary is employed by the Macon County Medical Society.

Future Activities Scheduled

A District interprofessional Meeting is scheduled for mid April of this year in association with the Professional Engineers.

Community Health Activities

The Macon County Medical Society Poliomyelitis Committee will conduct a Sabine oral vaccination program in March if this year.

Other Activities in the Seventh District

The ISMS 50-Year Club acquired two new members in the Seventh District during the past year. The first was Harvey D. Fehrenbacher, M.D., of Flora, Illinois who was presented with his Certificate and Pin at a banquet held in the Church of the Latter Day Saints on June 26, 1963. Mark Greer, M.D., the second recipient, was presented with his Certificate and Pin at a banquet in the Vandalia Community High School. Five hundred people attended in Dr. Greer's honor. Dr. Greer was voted the outstanding General Practitioner of the Year by the Illinois State Medical Society in 1959.

Governor Kerner of Illinois, and Harold M. Visotsky, M.D., Director of the Department of Mental Health, officiated at a ground breaking ceremony for the new Adolph Meyer Zone Center in Decatur on Tuesday February 25, 1964. This institution will be the second large Mental Health Center in the Seventh District. The first large Center is to be opened May 1, 1964 at Centralia, Illinois. It will be used for the treatment of mentally retarded children.

The medical staffs of the Decatur and Macon County Hospitals have made excellent contributions

to postgraduate medical education in central Illinois. In November 1963 a two and one-half day program on Gastroenterology was given by three leading Faculty Members of the University of Pennsylvania Graduate Medical School. On February 13, 1964 a ten-week course in "Practical Therapeutics" was begun. The course was given by the University of Illinois College of Medicine Faculty, through the Extension Division of the University of Illinois. The American Academy of General Practice has approved this course for Category 1 credit. It is your Trustee's understanding that this is the first such arrangement made in this State with the American Academy of General Practice.

Your Trustee has attended all Board of Trustee Meetings of ISMS during the past year. As a member of the Illinois Delegation to the AMA he attended the Atlantic City Session in June, 1963, and the Interim Session in Portland in December 1963. He also served on the ISMS Committee to Study Committees.

The Women's Auxiliary is to be complemented on its activities which cover not only the local Society areas but also State and National affairs.

Summary

There has been an increase of thirteen physicians in the Seventh District. The "Grievance" Committee has functioned in excellent fashion. There were outstanding County Medical Society activities in Diabetes and Disaster Programs, good interprofessional relationships, high quality Scientific and Postgraduate Meetings, and progress in increasing and improving the Mental Health Facilities. Two physicians were made members of the 50 Year Club.

Your Trustee greatly appreciates the cooperation on the part of the Constituent Societies and Auxiliaries of the Seventh District during this past year.

Arthur F. Goodyear, *Trustee*

EIGHTH DISTRICT

The trustee has attempted on two occasions to hold a district meeting on "Operation Home Town". The first meeting, scheduled for November 24, 1963, was cancelled because of the assassination of the President. After the thirty day mourning period a second attempt was made to hold a meeting on January 25, 1964. However, fate again intervened. This meeting had to be cancelled because a fire broke out in the meeting place.

The trustee has attended a special meeting of the Pharmacy Committee at the request of the secretary of the Vermillion County Medical Society. Policies and problems of the pharmacist were discussed by the president of the Illinois State Pharmaceutical Association at this meeting.

Your trustee has been present at two meetings of the district grievance committee.

A district meeting will be held previous to the annual meeting for the purpose of discussing the reports that will appear in the handbook. Also any resolutions deemed necessary to the house of delegates will be submitted.

Your trustee has furnished reports and surveys as requested by the president of the Illinois State Medical Society and the chairman of the specific committees.

Dr. W. H. Schowengerdt, *Trustee*

NINTH DISTRICT

There have been no particular changes in the membership or activities of Ninth District societies during the past year. A few new doctors have become members.

There has been no activity involving the Ethical Relations or Grievance Committes. No meeting of the Committee on Prepayment Plans and Organizations has taken place. Most of the county medical societies in this district hold regular meetings. They are active and have good scientific sessions. There has been little interest in postgraduate medical educational district meetings in this area.

The legislative programs, such as "Operation Hometown", have been taken up in some of the counties but not in all. However, interest is fairly good. At a district meeting of IMPAC there were only about 30 to 35 people in attendance from the whole Southern portion of the State. This was not a good turnout for such a meeting. It is apparent that some interest must be stimulated in our Legislative programs at the local level.

In the Ninth District we have one school of practical nursing in Harrisburg at which the Doctors lecture to nurses on various subjects. This nursing school has been in operation for the past several years and is doing an excellent job and furnishes good practical nurses for hospitals in this area.

We still have a communications problem, particularly at the grass roots level. It seems difficult to obtain local interest in many of the projects which are available from the State Society. I feel that more efforts should be made to stimuate and provide better communications from the state level to county medical societies.

I appreciate very much all the help and assistance given me by various county medical societies and particularly by the officers and staff of the Illinois State Medical Society. I hope that we shall continue to progress in the next few years as we have in the past few.

B. E. Montgomery, *Trustee of the Ninth District*

TENTH DISTRICT

On May 28, 1963 the newly elected Trustee sent a letter of inquiry, with stamped return envelope,

to each physician in the District's nine counties. There was a 12 per cent response. Of those responding, 60 per cent had attended none of the last three annual State meetings, 20 per cent had been to all three, 80 per cent expressed approval of the management of the Society's affairs, some 65 per cent believed the State Society fulfilled the individual physician's needs.

Where indicated, telephone and letter supplemented personal visits to each county Society.

No situation or circumstance arose requiring convening the three district committees.

Specifically, Alexander and Pulaski Counties seek added pediatric skills for their area and are making unusual and special effort to fill the void.

Perry County Society members emerged into public prominence by their united stand against smoking.

Union County physicians enjoy a fine esprit de corps. The appointment of one of their members to the State Maternal Welfare Committee has met with enthusiasm and approval.

Physicians in Monroe County practice cooperative flexibility in providing modern health services for their patients.

Washington County physicians claim to be first in completing their oral polio immunization program in 1962. They encounter considerable personal inconvenience in maintaining emergency coverage for each other in the vast area they serve.

Randolph County is to be commended for its members' personal entrance into the political contest for coroner's office. These colleagues furnished an unusual satisfaction in their decision to allocate funds from the treasury as follows:

$600 to the AMA-ERF
$300 to Benevolence
$600 to ISMS Science Foundation
$300 to the Illinois Assoc. Maternal and Infant Health

Jackson County has participated in the combined meeting of the 9th and 10th Districts in conjunction with the annual Southern Illinois Medical Society program last November, hosting a well planned and perfectly executed program in child health and perinatal committees that brought a fresh advancement to the overall health team effort.

The supportive and constructive rolls of ISMS official family and administrative staff have never been more evident than the influence on their concerted effort in *Operation Hometown* and participation in local political affairs.

St. Clair Society has again attained an anchor spot in the District's affairs by efforts of its members and auxiliary in public relations, public education in health, urban revitalization, religion and medicine conference, and sophisticated effort fostering constitutional government.

As of this writing, we have just held our 3rd annual banquet of the St. Clair County Nursing Scholarship Association, honoring some 40 scholarship student nurses attending nearby metropolitan schools. Over 200 physicians, auxiliary members, civic leaders, nurse educators, and guests heard President D. Morris of Southern Illinois University publicly announce again his plans for baccalaureate nursing education through utilization of clinical facilities within the greater East St. Louis area institutions.

As in the past, progress will be influenced by activities and affairs of the Southern Illinois Medical Society, delegates, officers, and daily excellence of service by individual physicians. The sustaining assistance of physicians' wives has not reached its full potential because of needed expansion of auxiliary formation in Tenth District.

W. C. Scrivner, *Trustee*

ELEVENTH DISTRICT

The component Medical Societies of the 11th District have continued their varied activities and conducted diversified scientific programs at their regular meetings. Public relations projects such as Health Fairs and weekly radio spots are sponsored by the executive personnel in two of the larger societies.

The administrative staff of the State Society has done a creditable job in the dissemination of information on the county and individual levels. It is aimed at keeping the membership more aware of many grave problems facing the medical profession today.

The District meeting was held on Oct. 16, 1963, at Pheasant Run in conjunction with the DuPage County Medical Society. The theme of the program was *The State Medical Society in Action.* Dr. E. A. Pizczek, President Elect of ISMS, reviewed the actions of the society. The administrative staff presented a question and answer period.

This meeting was planned far in advance. The luncheon was well attended, but a great many left before the District meeting got under way. It is for that reason that I feel that a reappraisal in regards to District meetings sponsored by the State Medical Society, is in order. It should be held primarily for officers and delgates of the County societies who may bring other interested members. The important thing is that we must continue to communicate with our delegates and County Society officers who will in turn be responsible for telling their members of the accomplishments of the Illinois State Medical Society.

The District Grievance and Ethical Relations Committees were called upon to consider two complaints in their respective fields. These have been carefully considered and both have been settled to the satisfaction of everyone concerned.

During the past year I have attended all the meetings of the Board of Trustees. I wish to take this opportunity to express my appreciation to the officers, Board of Trustees, and the Staff of the ISMS for their fine co-operation.

TRUSTEE AT LARGE

Report not available at publication time. Please check handbook index for late reports.

SPECIAL REPORTS

CHAIRMAN OF THE BOARD OF TRUSTEES

The first meeting of the 1963-64 Board of Trustees was held on Thursday, May 16, 1963. Subsequent meetings were held on July 20 and 21, 1963; October 5 and 6, 1963; and January 11 and 12, 1964. Additional meetings are planned for March 14 and 15, and May 17. These will be reported in a supplementary report.

Organization and Committee Appointments

At the May 16 meeting, Dr. Newton DuPuy was elected to succeed himself as chairman. New trustees were then appropriately introduced, and the membership of the Executive, Finance and Policy committees were announced. Final organiation of the Board committees for 1963-64 was completed at the July 20-21 meeting. These committees were approved for publication and dissemination to county medical societies.

Until this year, committees were published with the Constitution and Bylaws. This year, however, it was deemed advisable to prepare a separate publication for each. It was also agreed that Board members would not serve as members of committees, except in the cases of those committees which are made up of Board members only. The purpose of this dictum is to assure that Board members will have more time to act on factors such as policy determination and interpretation, and to the guidance of committee chairmen. This plan also provides for more representation of the general membership on committees.

Follow-up on Resolutions of the House of Delegates 1963

After each meeting of the House of Delegates, the Executive Administrator provides the Board with a listing of all resolutions which require follow-up. Specific assignments are then referred to committees and/or staff for implementation. The following implementation of resolutions passed in 1963 have been approved by the Board of Trustees. We hope that the House of Delegates will make any suggestions for further implementation.

Resolutions #62-2, 3, 4, 10, 13 and 18: The subject of these resolutions had to do with citizenship requirements for members. As a result of reference committee recommendations and appropriate amendments by the 1963 House of Delegates, the Bylaws now include an amended portion to provide for conditional membership for licensed physicians who are not citizens, but who fulfill all other requirements. Copies of the revised Constitution and Bylaws were published and made available to state and county society officers. Copies will also be made available in the delegate kits for review by the 1964 House of Delegates. This publication thus constitutes the report of the follow-up action on the above resolutions, as well as on other actions of the 1963 House of Delegates pertaining to amendment of the Constitution and Bylaws.

Resolution #63-6: The subject of this resolution was the establishment of a Section on General Practice. It was referred to the Committee to Study the Annual Convention. The committee reviewed the resolution, consulted the Illinois Academy of General Practice, and discussed the matter with the Chairman of the Committee on Scientific Assembly. It was decided that because the entire scientific program is supposed to be G.P.-oriented, the "specialization of general practice," was not in order. Therefore, the recommendation of the committee to the 1964 House of Delegates is that a Section on General Practice not be established.

Resolution #63-8: This resolution called for support of all legislation providing adequate state support for schools to avoid federal intervention. To eliminate reference to specific legislation, the original resolution was re-written by the reference committee. It was then referred by the Board of Trustees to the Committee on Legislation. The viewpoint of this resolution was promptly issued to the news media by the Public Relations staff after the 1963 meeting. It was also expressed and transmitted to members of the 73rd General Assembly by the Legislative Representatives of ISMS. This shall also be considered a policy for guidance of the Legislative Committee and its staff during future legislative sessions.

Resolution #63-9: "Lag in Payment for Services Rendered IPAC Patients," and *Resolution #63-20:* "Payment of Physicians Treating Recipients of Public Aid," were both referred by the Medical Advisory Committee to the Department of Public Aid. At its January meeting with representatives of the Department, the Advisory Committee pointed out the existing inequities in payments to physicians treating relief recipients. It urged Mr. Harold Swank, Director of the Illinois Department of Public Aid, to eliminate these inequities in payments to physicians by allowing payments to all physicians who treat public aid patients—regardless of their county of practice. Mr. Swank was further urged to include this in his 1965-67 regular budget request to the Governor. The matter will again be brought to the attention of appropriate persons prior to the time that the Department's budget is prepared.

At the same meeting, the Advisory Committee

pointed out the slowness with which payments to physicians are made. It was urged that the payment process be expedited and the payment lag be reduced as much and as soon as possible. Further follow-up and attention will be given to this subject if the lag in payment continues.

Resolution #63-12: The subject of this resolution was "The Public Image of the Doctor of Medicine." The resolution was specifically referred to the Board of Trustees for study. The Board then requested the Public Relations Committee to review past activities in this area, and to consider what might be done in the future to implement the intent of this resolution. The Public Relations Committee reported at the January 1964 meeting of the Board that it has drawn up a 10-point program upon which it hopes to build this "cultural" image. The Committee has directed staff to use this 10-point program as a guide toward publicizing the physician's image through the press, radio and television. The 10-point program is outlined as follows:

(1) That the physician's first concern is for the health and well being of his patients, regardless of financial remnueration.
(2) That he constantly strives to improve his professional skills through a disciplined program of continuing education.
(3) That he is morally obligated to keep the public informed on practical health matters through all available media and by public appearances.
(4) That he is obligated to protect the public from fraudulent and unethical practices.
(5) That he is an active force in determining the development and planning of health services and payment for these services.
(6) That he respects his right to practice medicine under the free enterprise system, and whenever challenged will defend this right with every vigor of his being.
(7) In recognizing the need for upholding the highest ethical and professional standards of his profession, he welcomes standards of close scrutiny by his professional colleagues.
(8) That his profession recognizes the excellent accomplishments of the other learned professions and wishes to participate actively with them in programs of humanitarian service.
(9) That his personal conduct is above reproach and in keeping with the highest moral standards of our society.
(10) That he is a good neighbor, respected citizen, and an active conscientious participant in community affairs.

Resolution #63-14: The subject of this resolution was the "Preliminary Relative Value Study." It was referred to the Committee on Relative Value for implementation. It directed the committee to revise the Relative Value Study, to print and distribute it to each member of the Society for his use as he sees fit, and that he be informed as to its use in private practice. In keeping with this directive, the Study has been revised. It is being prepared for reproduction and mailing to members of the House of Delegates, Presidents and Secretaries of County Societies, and other members of the Society who request a copy.

One portion of the resolution indicated that each member of the Society should receive a copy of the revised study. The Board of Trustees advised the committee to provide copies only upon request because it was estimated that to print and provide copies to each society member would cost approximately $10,000. It was the feeling of the Board that to provide a copy to all who desired it was to fulfill the intent of the resolution. It is hoped that the House of Delegates will accept this as appropriate and quite satisfactory.

Resolution #63-15: The subject of this resolution was to recommend a "Study and Evaluation of Toxicants." The Board of Trustees went on record to announce that efforts to manipulate ecologic balances by governmental agencies, by private industry, and by individuals through the use of toxicants and radiation requires urgent and conscientious study. The results of such study should provide the basis for the development of wise and effective controls.

In addition, the Director of the Illinois Department of Public Health—through the Bureau of Hazardous Substances and Poison Control—was requested to undertake a study of all current toxicants sold or used in Illinois. A study of future, or proposed, toxicants was also asked for. A report of these studies for appropriate distribution was to be made.

A similar resolution was presented to the AMA House of Delegates at its Atlantic City meeting in June. The AMA Board recommended that a panel on household and economic chemicals be established under the Adverse Reaction Section of the Council on Drugs, that Poison Prevention Committees be established (or that this activity be assigned to existing committees in the state and local medical societies), and that the related responsibilities of staff in this area be approved.

Resolution #63-16: The subject of this resolution was "Discovery Depositions for Physicians." It called for the elimination of abuses by lawyers on physicians' time in the taking of Discovery Depositions. The resolution has been presented to the Liaison Committee of the Illinois Bar Association by the ISMS Liaison Committee. Contingent upon support from the Bar Association, further follow-up with the Illinois Judicial Conference and the Supreme Court are anticipated.

Resolution #63-21: This resolution, which called for opposition to a series of bills then pending in Congress limiting the use of animals in medical research, was referred to the Committee on Legislation. ISMS opposition has been coordinated with that of the AMA through a task force made up

of representatives from other interested organizations. The bills have received no action, and remain in the Interstate and Foreign Commerce Committee. Copies of the resolution have been forwarded to Illinois senators and Illinois congressional delegations.

Resolutions #63-23 and 63-24: The subjects of these two resolutions requested state and federal legislation to help control casualties from flammable fabrics.

The ISMS supported and encouraged revision of the Federal Flammable Fabrics Act in a resolution to the American Medical Association House of Delegates at its Atlantic City meeting in June, 1963. At its Portland meeting in December, however, the AMA Board and Reference Committee agreed that the real solution to the problem did not rest in changing legislation, but in educating the public to prevent careless exposure of commonly used fabrics to combustion. The AMA recommended that such an educational program be initiated in cooperation with groups such as the National Safety Council, the American Academy of Pediatrics and the Fire Protection Association.

Resolution #63-25: This resolution expressed opposition to the Health Professions Assistance Act, and called for a change in the AMA position which supported the one-time grants for medical school construction (S 9-11, and H.R. 12). The ISMS president discussed the contents of this resolution with the Executive Vice President and other officers of the AMA. This discussion was prompted by an impending vote in the Senate after favorable House action.

A resolution opposing the Health Professions Assistance Act was introduced in the June 1963 AMA Annual Meeting by Delegate William K. Ford, M.D., of Rockford. In view of the former policy favoring one-time grants for "bricks and mortar," this resolution was not adopted. The AMA Reference Committee made a recommendation to review and revaluate the policy of the Association with respect to such grants. This recommendation was approved.

The Health Professions Act was approved by Congress and signed into law, despite the vigorous opposition by AMA to the provision for loans to medical school students.

Resolution #63-27: This resolution called for all county medical societies to support the Operation Hometown Campaign—in opposition to medical care under Social Security (H. R. 3920). This resolution was referred to the Committee on Legislation, and the Operation Hometown Campaign is being vigorously pursued in most county medical societies.

Resolution #63-29: This resolution indicated that physicians would continue to render care to those who were indigent until such time as the legislature passed the necessary appropriation. This action was given appropriate publicity. An immediate announcement was made to the public. The resolution was referred to the Committee on Public Relations for further guidance in publicizing the policies of the Illinois State Medical Society.

Follow-up Recommendations and Suggestions of Reference Committees of 1963

Reference committees comment upon review of reports and frequently make suggestions and recommendations which are not acted upon individually by the House of Delegates. The minutes and reference committee reports of 1963 have been carefully studied. The following reports chronicle the actions which have been taken on those suggestions which the Board and committees have implemented in order to complete the follow-up requirements.

Suggestions of the Reference Committee on Administrative Activities:

1. *That consideration be given to amending the By-laws to permit each Vice President the right to vote in meetings of the Board of Trustees, and that Vice Presidents be appointed as members of the major committees of the Society.*

The conclusions of the Committee on Constitution and Bylaws will be found in that Committee's report to the House of Delegates. The latter portion of the suggestion was implemented by the Chairman of the Board of Trustees when he appointed Dr. Charles Allison as 1st Vice President and Dr. Ted LeBoy as 2nd Vice President to serve on several important committees of the Society. Dr. Allison is Chairman of the Ethical Relations Committee. Dr. LeBoy serves as Chairman of the Committee on Nursing.

2. *That individual members of the profession be urged to give financial support to the Educational and Scientific Foundation.*

The Educational and Scientific Foundation has completed several projects this year. A brochure, based upon these the activities of projects—and those anticipated for the future—will be prepared shortly for distribution to all members of the Society. An annual report of the Foundation, as well as a financial report of those activities will be made available to the Reference Committee.

3. *That component Societies schedule the appearance of their Trustees at their meetings and utilize state officers and staff more frequently.*

The details of meetings scheduled, not only with individual county societies but also in district meetings, will be found in the reports of the Trustees. Particular emphasis will be placed on meetings with delegates and alternate delegates.

Officers of the Society and staff have been called upon more frequently this year to attend various meetings than in any previous year—insofar as I have been able to determine. The Legislative Representative working out of the Springfield office has been especially available to the counties down-

state. During the summer of 1963 an individual contact representative was assigned to the Chicago area. His specific function was to encourage participation in "Operation Hometown."

ISMS officers, particularly the President, the President-Elect, and the Chairman of the Board of Trustees have always been available when called upon. They have rendered valuable service during the past year at county society meetings, and at district meetings of the societies.

4. *Urge the continuance of annual workshop conferences for committee chairman.*

On October 5, 1963 a conference of committee chairmen was held to discuss the preparation of policy statements for submission to the House of Delegates. A full report on this meeting will be found in the Report of the Committee on Policy.

It is planned and included in the budget for 1964 that a similar meeting will be held in the fall of this year.

5. *Urge the Board of Trustees to have a written set of policies available for the consideration of the House at the 1964 meeting.*

For two years the House of Delegates has concurred with the suggestion that a Policy Manual be developed. To this end, the Policy Committee has prepared a written report for consideration by the House. A list of items on which policy statements will be developed for the consideration of the House, will be found in the packet of materials to be distributed to the House members.

This project will present a time consuming problem for the Policy Committee until such time as a complete manual is prepared. The material in the manual will be assembled in an abbreviated, carefully edited from which will facilitate annual amendments by the House as they are indicated. Members of the committee are convinced that the final product will not be available for several years. Further sustained effort and a careful evaluation of all premises are necessary before the project is completed.

6. *That Deans of the medical schools be requested to submit a general summary of the expenditures of ISMS donations to the AMA-ERF.*

The Chairman of the Committee on Medical Education and Hospitals requested that the deans of the medical schools provide him with brief statements describing how these funds are used. These reports will be summarized and presented to the House of Delegates. Dr. Daniel S. Kuschner, Dean of the Chicago Medical School will present the report.

Recommendations of the Reference Committee on Constitution and By-laws:

The reference committee made specific recommendations regarding changes in the By-laws which have been included in the published Constitution and By-laws. These recommendations will be included in the packet prepared for the House of Delegates. They include: (1) amendments of the provision concerning membership in the State Medical Society for non-citizens; (2) inclusion of the Chairman of the Policy Committee as a member of the Executive Committee and of the Secretary-Treasurer as a member of the Finance Committee, (3) the establishment of a February 1 deadline for secretaries of county medical societies to notify ISMS of officers, delegates and alternate delegates, and (4) the inclusion of the following categories as constitutional committees: Disaster Medical Care, Laboratory Evaluation, Occupational Health, and Public Safety.

Reference Committee on Economics and Legislative Activities:

1. *Urge continuation of work with the Illinois Public Aid Commission in order to assure success of the Kerr-Mills program in the State of Illinois.*

Very helpful information about the Kerr-Mills program has been provided to the county medical societies. In addition, the IMJ has published several articles which provided members of the Society with details on the Kerr-Mills program.

During the 1963 legislative session proper amendments relating to the success of Kerr-Mills, which have been announced to the membership, were made. These are continually under surveillance by the Medical Advisory Committee to the Illinois Public Aid Department as to their applicability and importance.

2. The House approved action taken by the Advisory Committee to the IPAC Department on Family Planning services. Within the year certain other aspects of this problem have come to the attention of the Board of Trustees. At its January meeting, for example, the Board of Trustees thought that it should request the House of Delegates to consider its future policy regarding the birth control issue. Appropriate comment is made in the report of the President on this item. Background material will be provided to the reference committee on this important subject so that the reference committee may consider the future importance of developing a policy on this subject.

3. *Urge the profession in Illinois to cooperate with the Department of Public Aid by prescribing drugs listed in the Drug Manual prepared by the Subcommittee on Drug Formulary for public aid recipients.*

A drug manual has been developed for the Illinois Public Aid Department. The Advisory Committee has continued its liaison through the year with the Department in order to keep the drug manual effective and up to date. Notification of additional changes will be given to the chairmen of county advisory committees, and to society secretaries.

4. *That V.A. hospitals should provide care only for service connected disabilities, except in those instances when the veteran is financially unable to pay for such medical and hospital care as indi-*

cated by a means test.

Services rendered to veterans for non-service connected disabilities is on the agenda of the Fee Schedule Committee for its next meeting. This matter is presently undergoing study, and the recommendation of the committee will be submitted to the House of Delegates in a supplementary report.

5. *That Committees on Aging be set up in each county society, and each county society urged to see to it that this committee functions in the broad and important areas of the aging.*

A letter was sent to all county society officers on February 6, 1964, recommended that committees on aging be established by each county society. The functions and purposes of such a committee were outlined in the letter. Attention was also called to the fact that district committees have been appointed to serve in a similar capacity at the district level.

6. *That the State Medical Society lend assistance to the Illinois Hospital Association wherever possible to accomplish hospital accreditation of non-accredited hospitals.*

The Hospital Relations Committee of ISMS has offered to help implement the Illinois Hospital Association's program aimed at accrediting non-accredited hospitals. The Committee plans another meeting with the Illinois Hospital Association to pursue the matter further.

7. *Encourage further simplification of Insurance Claim Forms through closer liaison with the Health Insurance Council.*

The action of the House of Delegates relative to further simplification of insurance claim forms has been brought to the attention of the Prepayment Plans and Organizations Committee. The subject is on the agenda for a meeting scheduled for March 3, and will be reported in a supplementary report to the House of Delegates.

Reference Committee on Scientific Activities:

1. *That the IMT program be developed and extended.*

The IMT Committee has initiated contacts with component societies to offer speakers on IMT. A special newsletter is being distributed to physicians serving on the panel of impartial witnesses. A recent survey of this group showed overwhelming support of the program. Further efforts to gain greater support of IMT from the judges and lawyers are being made through the Liaison Committee with the Illinois and American Bar Associations.

Continued financial support from Foundations has been secured through July 1, 1965.

2. *Registered strong opposition to proposed centralized state licensure of laboratories and blood banks, and emphasized the necessity for close scrutiny of laboratories by qualified personnel.*

The Committee on Laboratory Evaluation requested the formation of Laboratory Evaluation Committees in all county medical societies and in branch societies of the Chicago Medical Society. Suggestions on the functioning of these committees, and on the supervision of laboratories at the local level, have been distributed.

Legislation passed by the 73rd Illinois General Assembly requires the registration of laboratories, blood banks and blood bank depositories. It provides for a commission to study any need for further legislation in this field. The Chairman of the ISMS Laboratory Committee is a member of this Commission. We are co-operating with the Department of Public Health in the provisions of this act. This is expected to enhance the Committee's efforts by identifying the location of all existing laboratories.

3. *Urge county societies to become deeply interested in all phases of mental and emotional health.*

The chairman of the Committee on Mental Health wrote to all county medical societies on July 12, 1963, requesting the appointment of county mental health chairmen. All of these chairmen were invited to attend the Illinois Mental Health Congress on October 19, 1963.

4. *Urge that each county society work with community groups to make suitable arrangements in the development of adequate tuberculin programs.*

A letter dated November 21, 1963, was sent to each county medical society president urging his attention to this problem.

5. *A special committee to be appointed to Study the Annual meeting, the problems of attendance, technical exhibits, and section meetings.*

A special committee, which was appointed by the Board of Trustees, met on October 3, 1963, and on February 13, 1964. A report of this committee and its preliminary recommendations is included in the annual reports to the House of Delegates.

6. *Urge the Illinois Department of Public Health to develop rules and regulations on radiation in keeping with the Atomic Energy Commission.*

The Committee on Radiation has prepared recommendations which cover the handling of radioactive materials. These recommendations, which were approved by the Board of Trustees, have been submitted to the Director of the Illinois Department of Public Health for his guidance.

Reference Committee on Public Relations:

1. *Urge the medical profession to participate in the implementation of the Medical Self Help Training Program.*

Since the Illinois Department of Public Health had already been charged with the responsibility of implementing this program through its county health departments, the Disaster Medical Care Committee sought to implement these efforts with a series of telecasts describing its program. With the aid of a $10,000 grant from the Department of Public Health, the Committee launched a 16-week television course over Station WTTW, Channel 11,

Chicago, on October 10, 1963. More than 10,000 students were enrolled.

The program was hailed as one of the most effective public service projects ever to be presented in the Chicago area by all press, radio, and television media. More than 1,000 persons completed the course and took the prescribed examination. The program carried a weekly audience of more than 500,000 viewers, and served as an excellent promotion for the Medical Self Help Training courses presently being given in Cook, Lake, Will, Kane and DuPage counties. This same course also won the acclaim of the U. S. Department of Civil Defense, the Illinois Department of Public Health, the AMA, as well as the general public. Copies of the films have been produced. These are made available to all county societies to aid them in teaching the Medical Self Help program.

2. *Urge county societies to form speakers bureaus.*

This request was called to the attention of secretaries of county medical societies in a letter from the Public Relations Committee dated January 31, 1964. Accompanying the letter was an eight page instruction booklet entitled "How to Establish a County Medical Society Speakers Bureau." This program, which was prepared especially for Illinois County Societies, presented a detailed plan of approach to the formation of speakers bureaus, including form letters of solicitation and appreciation, enlistment, and request forms.

3. *Urge each physician to discuss fees with his patients before proceeding with regular treatment.*

The Grievance Committee conveyed this request to all members of the State Society through a Journal article prepared by Committee Chairman Arkell M. Vaughn. This article was published in the April 1964 issue of IMJ.

Reference Committee on Miscellaneous Business:

1. *To further define the objectives of the Illinois Association of the Professions and consider possible future expansion to include paramedical groups.*

A complete report of the Committee to Form an Illinois Association of the Profession has been submitted to the House of Delegates. The objectives and purposes have been clearly defined in the Constitution and Bylaws of the Association. An Eligibility Committee will be appointed in the very near future. It will consider applications from other paramedical groups indicated and mentioned by the House of Delegates at the 1963 meeting.

2. Asked: *That the Committee to Redistrict the Society continue to study and submit a report to the 1964 meeting.*

A separate report on this committee's activities has been submitted to the House of Delegates. A questionnaire was devised and sent to all officers and trustees of the society. Other aspects of this problem continue to be under study by the Committee.

3. Requested: *To provide to the Attorney General continued assistance to report in the area of quackery.*

The Committee on Quackery and the officers and staff of the Society have throughout this year reported to the Attorney General and the Department of Registration and Education all instances where a problem of quackery is reported or appears, or an instance in which an individual practices without appropriate licensure. This reporting system will be continued on a regular basis.

4. Suggested: *The use of joint meetings of the Auxiliary with county medical societies.*

Although such joint meetings have not been possible in many instances, the report of the president of the Auxiliary will indicate that considerable advancement has indeed been made, and that joint meetings are being held in many districts. The cooperation of the Auxiliary and the officers and staff of the Society in this effort has proved to be exceedingly valuable during the past year.

5. *Tabled the report of the Committee to Study Osteopathic Relations and discharged the committee.*

As indicated, this committee was appropriately discharged following the 1963 meeting of the House. This committee has been reconstituted, however, in answer to a request from the AMA. It has met with the corresponding AMA committee to consider further aspects of this problem. The report of this committee's activities will be contained in the Supplementary Report of the Board of Trustees.

The Director of the Department of Public Health and the Department of Mental Health

Attached to this report as *Appendix A* is a report prepared by Franklin D. Yoder, M.D., Director of the Department of Public Health. This report covers many facets of the Department's activities. Dr. Yoder has attended all meetings of the Board of Trustees. He is to be commended for his co-operation and interest in the programs and progress of our society. Furthermore, he has extended the cooperation of each of his division directors to the officers, committees, and staff of ISMS. He has made it possible for the State Medical Society to bring various problems dealing with the health of the people of the State of Illinois before the Governor. We commend Dr. Yoder highly for his attention to duty. We also wish to cite excellent cooperation of his fine staff.

Attached as *Appendix B* is the report of Harold M. Visotsky, M.D., the Director of the Department of Mental Health. Dr. Visotsky has also attended several meetings of the Board of Trustees. He has also extended his co-operation to the Board, as well as to our Committee on Mental Health, and to the development of an adequate mental health program for the State of Illinois. We extend our thanks and

appreciation to Dr. Visotsky for his efforts in this respect.

Other Actions of the Board of Trustees

A. To avoid unnecessary duplication, the balance of this report will be restricted to recording those actions of the Board that are not fully covered in committee reports. A sizeable portion of each Board meeting is devoted to the review of committee reports and their current activities. Because all committee projects require Board approval, we recommend a thorough reading of these committee reports in order that you may obtain a complete understanding of your Society's activities.

B. Not ordinarily included in other reports are specific actions by the Board as well as administrative decisions which should be reviewed by the House of Delegates. Those which we consider were the most important throughout the past year are as follows:

1. Special Representatives of ISMS

The President, President Elect, Chairman of the Board, and other officers give much of their time to representing the Society at both official and unofficial functions. Many of our committee chairman also represent the Society at similar functions. We will not attempt to list those who served in this capacity. But as the Chairman of the Board of Trustees, I wish to express appreciation to those who have served. The minutes of the Board of Trustees are replete with specific references to individual contributions of this nature. These can be identified should the House of Delegates desire a more complete listing.

2. Political Action Committee

As in 1962, the Board of Trustees granted funds to the Illinois Medical Political Action Committee for a continuance of its political education activities in 1963. This committee has inspired physicians to take more active roles in political matters. After careful consideration, $9,000 was made available to IMPAC with the understanding that a report on the expenditure of these funds would be submitted to the Board of Trustees. Such a report has been received and will be presented to the March 14, 1964 meeting of the Board.

3. New Committees

During the year a number of new committees were appointed in order to carry out directives issued by the House of Delegates and by the Board of Trustees. One such committee is the Liaison Committee with Blue Cross-Blue Shield. Its specific function will be to provide a two-way channel of communication between Blue Cross-Blue Shield Plans and ISMS on matters of mutual interest and concern. Appropriate committees have been appointed by BS and BC. It is planned that they will meet within the next few months to discuss specific problems of mutual interest.

Another committee which was appointed is the Committee on Public Affairs. This committee has the responsibility of acquainting members of the medical profession—and their wives—on political issues which confront citizens of the United States. It was formed to encourage participation by physicians and their families in those public affairs and community activities which lead to a better understanding of the methods by which the decisions of state and federal government are determined. A complete report of this committee and its activities will be presented directly to the House of Delegates. An appropriate budget has been provided for this committee. It is hoped that the stimulation of members in the area of public affairs will, in the final analysis, assist in determining the manner in which medicine will be practiced in the future.

A third committee authorized for appointment was one designated to study the ramifications of the Federal Food and Drug Administration's rulings on Krebiozen. Inasmuch as the federal government has ruled that Krebiozen should not be distributed via interstate commerce, it was this committee's responsibility to examine existing state laws to determine whether or not an injunction could be secured by the Attorney General's office to halt the sale and distribution of Krebiozen in Illinois. Recent research by the Attorney General suggests that under present law there is no way in which he can prohibit the sale of Krebiozen in Illinois. However, this problem continues to be studied by appropriate state and federal agencies. Any further progress will be reported in a supplementary report.

4. Budget

The budget for ISMS is prepared on a calendar year. Details of expenditures made during 1963 will be found in the report of the Secretary-Treasurer and in the accountant's report, which will be found in the packet for the members of the House of Delegates. The Finance Committee has carefully scrutinized all expenditures, and it has prepared a monthly financial statement for the Board of Trustees.

The Finance Committee has presented a budget for 1964. We are currently operating under this budget. Although this budget is $32,000 in deficit, it is anticipated that with the reserves accumulated in 1963, and the possibility that expenditures will not be as high as anticipated, the deficit for the year 1964 may be somewhat less than anticipated. We do not anticipate any increase in the dues structures for the year 1965. The Board of Trustees will be prepared to make its recommendations on dues at the final session of the House of Delegates.

5. Executive Committee

In previous sections of this report we have referred to actions by the Finance and Policy Committees of the Board of Trustees. The Executive

Committee performs the function of screening many of the Society's detailed administrative actions which take place between, and immediately prior to, sessions of the Board of Trustees. All actions of the Executive Committee are submitted to the Board of Trustees as written reports. These reports are reviewed by the Board of Trustees prior to final approval.

It is important for the membership of the House to realize how practically impossible it is to reduce the many detailed activities of ISMS into written reports for review by the House members. However, the minutes of the Executive Committee meetings are available for review at any time by any member of the Society.

6. New Lease for Headquarters Office

During the past year the headquarters office facilities were reviewed by the officers, the Finance Committee, and the Executive Administrator. It had at first been proposed that the headquarters be moved to 310 South Michigan Avenue. A study by the Finance Committee, however, concluded that such a move would be more costly and less convenient than had been anticipated in a report to the last House of Delegates. Thus it was deemed proper that on the basis of a very favorable lease and more adequate space for storage, equipment, and supplies, etc., that the Executive Administrator be authorized to renegotiate a lease in the present headquarters until 1975. Such a lease has been negotiated and signed to the satisfaction of the Executive Committee, the Finance Committee, and the Board of Trustees.

7. Employees Dinner

In conjunction with the meeting of the Board of Trustees in January, 1964, all employees were entertained with an official dinner at which the officers gave special recognition for employee contributions to the efforts of the Society. This dinner was especially noteworthy because the Board was also able to recognize previous members of the Board of Trustees who had at one time served the Society but who had received no formal recognition for such service. The annual dinner has proved to be well received by the employees, the officers, their wives, and will probably be continued in the forthcoming years.

8. Chartered Tour to Mexico

In 1963 the Board of Trustees gave its approval to a sponsored chartered tour of Europe for members of the Society. Unexpectedly, this tour attracted a large number of people. This year the Board of Trustees has given approval to a tour to Mexico immediately following the annual meeting. There will be a continuance of scientific programs in Mexico City. At the time of the preparation of this report, we are unable to indicate how successful the subscription to this tour has been. Additional information will be available at the time of the annual meeting for the reference committee.

9. Headquarters Staff

The executive staff of the State Society continues to be administered by Mr. Robert L. Richards. As indicated in last year's report, he is presently employed under a five year contract. He will report on several important administrative changes that have been made in his written report to the House of Delegates, and in his oral remarks. It is important that the House of Delegates be aware of the continuous administrative reports that are made available to the officers and Board of Trustees. All such reports appear in writing and are carefully reviewed by the Board at each of its meetings. In the interim between sessions of the Board of Trustees, the Administrator calls upon the Chairman of the Board and the Executive Committee for detailed guidance.

As Chairman of the Board during the past year, I wish to emphasize that nothing of significance or importance has been acted upon without proper review by myself, or by the other officers. It is hoped that we will be able to maintain the high quality and efficient staff which has been assembled and organized during the past four years.

10. Auxiliary Services

During the current year, relations between the Auxiliary and the State Society have been carefully reviewed. Administrative procedures have been outlined by the Executive Administrator in order to provide more adequate secretarial and staff assistance to the officers of the Auxiliary. Furthermore, the committees of the Society were reviewed for the purpose of having Auxiliary members represented as liaison officers. In many instances such as in Legislation, Public Affairs, Public Relations, Aging, Public Safety, etc., the Auxiliary now provides official liaison representatives to work with state society committees. We feel that the Auxiliary cooperation in this respect has been most commendatory.

11. New Department of Public Aid

During the 1963 legislature, the Illinois Public Aid Commission was officially disbanded. A new Department of Public Aid was created to take the Commission's place. The Society, through its President, extended official communications to the Governor offering to continue the services of the Medical Advisory Committees at the state and county levels. The Director of the Public Aid Department has expressed his desire that these services be continued in order that efficient and effective medical care are provided under public aid programs in Illinois.

12. Congressional Hearings

The Society was officially requested to appear

before Congressional hearings on HR 3920 (King-Anderson) held in Washington, D. C. Official representatives of ISMS appeared and submitted what was later commented upon as an excellent presentation.

The Society also provided official representatives to hearings held by the Internal Revenue Service on Professional Incorporation Laws passed by several state legislatures, including that of Illinois. It is highly doubtful that this representation will have any significant effect on the IRS determination to declare the state laws as invalid. However, a further report on this item will not be available until some later time—perhaps to be included in the supplementary report of the Board of Trustees.

12. Legislative Actions

The 73rd General Assembly concluded its sessions after the 63rd meeting of the House of Delegates. A final report on the legislation passed, and the actions of our Committee on Legislation, was transmitted to all members of the Society, and it was published in the IMJ.

Furthermore, the Committee on Legislation's reports, which will be presented to the House of Delegates, will contain many of the details of their activities. As Chairman of the Board of Trustees, I should like to merely comment that the work of this committee has been excellently executed during the past year, and that they are presently preparing the legislative program for 1964-65. This work also includes such legislative action as is deemed necessary to defeat the King-Anderson proposal in Congress, as well as the preparation of detailed legislation to be introduced into the 74th General Assembly of the State of Illinois.

13. National Environmental Health Center

It has come to the attention of the Board of Trustees that the U.S.P.H.S. is considering the establishment of a new Environmental Health Center. The purpose of such a center would be to study and evaluate environmental problems such as air pollution, water supply and pollution, radiation, transportation, and weather. In a joint project shared by the State Health Department, the deans of five medical schools, and the deans of several engineering schools, the Society has prepared a report describing the advantages of Chicago as an ideal site for this proposed Center. We believe that the location of the Environmental Health Center should be based on considerations of what will prove to be best for the entire country. We have therefore taken the position that Chicago should be suggested as a possible site for such a Center.

14. Schools of Public Health

The Board of Trustees continues to be interested in the establishment of a School of Public Health in Illinois. The Board has endorsed the efforts of the Director of Public Health to establish such educational facilities. We have co-operated with the University of Illinois in providing information and data for a Survey of Medical Facilities being conducted by Mr. Lester Evans of New York City. This survey is under the sponsorship of the University of Illinois.

The ISMS President, Dr. English, has personally assisted Mr. Evans in acquiring the data for his survey. We commend Dr. English for his interest and insight into this problem.

15. Blood Alcohol Studies

The Board has approved the Department of Public Health's policy of conducting blood alcohol level studies in all fatalities involving drivers or occupants of automobiles, and pedestrians. The facilities of the Division of Laboratories of the Department of Public Health are sufficient to handle the processing of the blood determinations.

16. Sera For Immunization Programs

The Board has approved that the Department of Public Health provide sera for the immunization of city and county employees such as police officers, fireman, volunteer civil defense workers, etc. This should be done if the local county medical society so requests and desires to provide this civic service.

17. School Health Examinations

The Board has reiterated a previous policy statement that "the health examination of school children should be performed by the family physician or pediatrician in the physician's office or clinic, and not in the school."

18. Battered Child Legislation

The Board has authorized the Committee on Legislation to develop legislation to protect the physician who reports the "abused," or "battered" child to the proper authorities. A sample bill prepared by the AMA's legal department has been submitted for consideration.

19. Teenage Smoking

The Board has supported a resolution recommended by the Committee on Child Health to the effect that the Society should conduct a program designed to prevent children from starting to smoke, and also influence teen-ager smokers to discontinue the habit. The Committee on Scientific Assembly and the Journal Committee are presently studying a proposal that the ISMS Journal refrain from carrying any further advertisements of cigarette companies, and that no exhibit at the Annual Convention be sold to cigarette companies.

20. Policy on Free Choice by Patients

Because several questions which have been raised

regarding the right of patients to choose physicians and vice versa, the Board of Trustees has prepared a statement of policy concerning Freedom of Choice among physicians and patients. This statement, as approved at the January 12, 1964 meeting of the Board of Trustees, is as follows:

"The Board of Trustees of the Illinois State Medical Society reaffirms its approval and defense of the mutual right of physicians and patients to exercise freedom of choice in medical matters. The Illinois State Medical Society, and the medical profession as a whole, have defended vigorously and consistently the right of patients to choose freely the physician by whom they will be served. The profession has also defended the right of physician, except in emergencies, to a corresponding freedom of choice. This right is stated clearly in Section Five of the Principles of Ethics of the American Medical Association to which all ethical physicians subscribe. These Principles of Ethics can be amended only by the House of Delegates of the American Medical Association. They cannot be altered or abrogated by any State Medical Society or by any ethical physician.

In recent months, an attempt has been made, most improperly, to inject into this basic freedom of choice the elements of discrimination and racial prejudice. These are matters which are totally unrelated, and the public can only be confused by efforts to equate them.

The fundamental value involved here is coercion, not discrimination or prejudice. The Illinois State Medical Society numbers among its membership physicians of many national, racial and religious backgrounds, all of whom enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct. Each of these physicians must continue to have the freedom and right to practice good medicine according to the dictates of his own conscience, and this must include his right to decide whom he can in good conscience serve. If his rights in this regard can be taken away, so then also can the rights of the patients of all physicians.

The Illinois State Medical Service has never practiced, endorsed or approved of racial or religious discrimination. Neither does it believe that the rights of some of our citizens can effectively be protected or preserved through the arbitrary curtailment of the rights of other citizens."

21. Drug Formulary

The Board of Trustees has approved a special Drug Formulary which was submitted to the Illinois Department of Public Aid. The express purpose of this formulary is to "save tax dollars under the Public Aid program." The formulary listing in no way constitutes an endorsement of any particular drug, nor does the omission of any specific pharmaceutical product indicate disapproval of that agent.

22. Disability Determination

The Board approved the vestment of authority in Department of Public Aid to process disability determination directly through a review team. In the past some decisions have been delayed because county advisory committees have failed to act. In order to meet the requirements of the Department of Health, Education and Welfare, disability determinations should be cleared within a period of 90 days.

23. Benevolence Committee Finances

In a January, 1964 report the Benevolence Committee requested an allocation of $5 per member to the Benevolence reserve fund until this fund reaches $300,000. The Committee also requested permission to solicit contributions from emeritus and retired members of the Society who are exempt from paying dues, yet who enjoy all the benefits of membership. These requests have been referred to the Finance Committee for consideration and recommendations to the House of Delegates. The disposition of these requests will be included in a supplementary report.

24. Recommendations of Committee on Constitution and By-laws

The Chairman of the Committee on Constitution and By-laws presented proposed changes at the January meeting of the Board of Trustees. The Board concurred in the proposed revisions presented by that Committee. A further report of the committee will be submitted directly to the House of Delegates.

Supplementary Report

As indicated in the opening of this report, the Board of Trustees will have at least one more meeting before the Annual Convention. A supplementary report covering items discussed between March 1 and May 18 will be submitted to the House of Delegates.

In this, my second year as Chairman of the Board of Trustees, I am truly grateful for the cooperation and efforts of the officers, committee chairmen and staff. It has been a pleasure serving as Chairman of the Board of Trustees for the past two years, and I trust that my tenure of office has been satisfactory to all those who have served with me in a program designed to improve the services of organized medicine.

Newton DuPuy

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

The over-all goal of the Illinois Department of Public Health is to attain—and to maintain—the highest possible standard of health for the people that it serves. To help accomplish this monumental objective, the Department is obliged to enlist the cooperation of private physicians who practice in this state. Such cooperation is, of course, practically impossible without the active collaboration of professional societies to which these physicians belong. Significantly, the Illinois Department of Public Health continues to enjoy excellent liaison with the Illinois State Medical Society.

Not too long ago, the functions of a public health department were confined to activities such as epidemic control, venereal disease control, some phases of preventive medicine, food inspection, etc. The modern department is, indeed, still concerned with these "classic" activities. In recent years, however, new and infinitely more complex functions have been heaped upon the public health department. Contamination of the atmosphere by the use of nuclear energy, for example, presents new problems of medical significance which must necessarily be studied and solved by the public health department.

Listed and described below are some of the functions that the Illinois Department of Public Health performs.

Some Functions of the Department

Basically, the Department provides services which the individual cannot provide for himself. It also helps to develop an understanding of what people must do for themselves, and what they can accomplish cooperatively in their communities when backed by the authority vested in their state and local official health agencies. The Department strives to keep citizens informed about health conditions through all media of public information. The *Illinois Health Messenger*, published monthly, is one example of a communications piece that is available to the public.

The Department requires that all births, deaths, and certain communicable disease must be reported. From statistical studies communicable disease reports, health officials learn what diseases are most prevalent, which age groups are significantly affected, where fatalities occur most frequently, and other vital information necessary to the maintenance and promotion of the public's health.

Of its 10,330,000 population, Illinois has about one million nonwhite persons, and about one million persons who are 65 years of age or older. These two groups present public health problems, because a higher proportion of their members are in financially deprived circumstances. The proportion of the population under age 15 is growing rapidly. This represents another dependent age group.

Birth and Death Statistics

There has been a slow but steady decline in the birth rate since the all-time high rate of 25.0 per 1,000 population in 1957. In 1962, the rate was 22.3. There were 230,484 babies born in Illinois in that year. However, health improvements and shifts in population by age held the death rate for all ages quite uniformly between 10 and 11.5 per 1,000 population during the past 40 years. The death rate in 1962 was 10.1 per 1,000 population, or a total of 104,695 deaths among Illinois residents.

The death rate of infants (those under one year old) was 24.0 per 1,000 live births, one-third of what it was in 1925. In 1962, 26.5 per cent of the infant deaths were in the one-to-eleven month age group, as compared to 42.5 per cent in 1925. Even so, 1,466 children in this age group died in 1962. Influenza and pneumonia killed 716, or 48.8 per cent. Congenital malformations were the cause of death in 281 cases, or 19.2 per cent. Accidents, ranked third as the cause of death. They accounted for 108 deaths, or 7.4 per cent.

A quick summation of these statistics reveals that the proportion of deaths in the over-one-month-old infant continues to decline as a result of the continued improvement in the child's environment. Nevertheless, about 56 per cent of the deaths in this age bracket were preventable.

There were three maternal deaths for every 10,000 live births in 1962—just half of what it was in 1950.

In its concern for the preservation of life among the very young, the Department emphasizes the care of babies born prematurely. During the fiscal year period ended June 30, 1963, the six premature centers in the state took care of 1,522 prematures. These were either born in—or transported to—such centers under the Department's program for specialized care for prematurely born infants. Other phases of this program include in-service special training of nurses in premature care, consultation service to hospitals, as well as incubator loan service for small hospitals.

Preventive Medical Services Expand

A program dedicated to the detection and treatment of phenylketonuria, was inaugurated in mid-1961. The program includes the provision of dietary assistance to those eligible, medical supervision, research, diagnostic and screening tests, laboratory service, a central registry for the state, cooperation with the Mental Health Department, and long-term follow-up of susceptible families. At the end of 1963, 54 phenylketonuric children were receiving services of this nature.

Two million doses of live oral polio vaccine were distributed by the Department to assist local mass immunization programs in 1963. Present budget limitations do not permit further distribution of the oral vaccine. However, physicians in local com-

munities are carrying on these immunization programs.

Biologicals distributed by the Department include those for the prevention of whooping cough, typhoid, diphtheria, tetanus and smallpox. In connection with smallpox prevention, the Department also supplies—upon the physician's request—vaccinia immune globulin (VIG). Gamma globulin is also distributed to physicians upon request for the treatment of hypogammaglobulinemia and agammaglobulinemia cases. About 150 persons—mostly children—are on registry to receive this monthly. Gamma globulin purchased by the Department is in addition to that supplied by the Americal National Red Cross through the Department for the prophylaxis of measles and infectious hepatitis contacts. While still unable to supply the new live measles virus vaccine, the Department purchased a considerable amount of gamma globulin (titrated for measles antibody content) for use in conjunction with the live virus measles vaccine purchased and administered by physicians.

The continuing rise in infectious syphilis and gonorrhea—particularly among teen-agers and young adults—demands increased preventive measures. Intensified epidemiologic follow-up and expanded educational efforts are two major aspects of this action. The U.S. Public Health Service cooperates by providing highly-trained professional interview-investigators in those areas of high incidence where the local budget is inadequate to sustain such services. With the cooperation of the U.S. Public Health Service, an attempt is being made to visit each physician in the state for the purpose of (1) encouraging him to report every venereal disease case and (2) to offer health department services to him—including drugs and consultative services.

Activity directed toward obtaining complete reports of serologies performed at private and hospital laboratories is being accelerated. In this way, results thus obtained may be followed up.

The Department's program for the prevention and control of accidental poisoning in children and the administration of the Illinois Uniform Hazardous Substances Labeling Act continues to expand. There are now 88 poison control centers located in Illinois hospitals. Accidental poisoning cases are treated at these center, which also serve as information centers 24 hours daily. Each center is supplied with current reference cards on toxicity of poisonous substances. Procedures have been initiated for Illinois cooperation with the Food and Drug Administration in supplying information on poisoning cases due to specific substances.

The school health program has been reactivated. A vision conservation coordinator has been employed. By mid-1964 a hearing conservationist will be employed to coordinate screening programs along these lines in schools in the state.

The veterinary public health program was reinstituted in mid-1963. The primary emphasis of the program is on delineating the exact means by which animal diseases are transmitted to man, and on the controls which must be established to prevent such transmission. Accomplishment of this goal requires the close cooperation of the Department with the Departments of Agriculture and Conservation, the University of Illinois College of Veterinary Medicine, the Center for Zoonoses Research, and the practicing veterinarians in the state. A veterinary advisory board to the Department has been appointed.

The statutes, regulations and policies relating to rabies control in man and animals are being studied in detail. It is anticipated that such a study will result in the elimination of conflicts and discrepancies which now exist.

A Q-fever survey has been initiated in the northern counties. In 1964, studies regarding the importance of the zoonoses in selected occupations are to be carried out. The possibility of cheese as a vehicle of Q fever transmission to man is being particularly investigated, as is the significance of pets as reservoirs of human salmonellosis.

The Department is cooperating with the Illinois Hospital Association, the Illinois State Medical Society, and the state Department of Public Safety in a four-year program with the Cornell University Automotive Crash Injury Research project. This project is to end in April, 1964. Purposes of this study are to obtain reliable data on the frequency, nature and specific types of injuries occurring in highway passenger car accidents. The Department serves as the medical coordinating unit. It assembles the accident histories and forwards them to Cornell.

Intensification of Laboratory Services

New technical advances have greatly extended the capabilities of laboratory workers to detect many different virus infections.

Several of the more important new laboratory services have been related to recent developments in fluorescence microscopy. This technique has been used for rapid typing of streptococci taken from throat swabs, pathogenic strains of *E. coli* taken from rectal swabs and stool specimens of patients with diarrhea, rapid diagnosis of rabies in animals determined from brain tissues, and as a dependable check against standard tests for syphilis. Several other possible applications of this technique are under study.

A new radioactive test has been developed in state laboratories for emergency use in detection of water pollution. By using this method, technicians can determine within several hours, if a water supply is contaminated. This can prove to be of inestimable value in times of disaster.

Through its laboratories located in Springfield, Chicago, Champaign, Carbondale, East St. Louis and Rock Island, the Department brings diagnostic and sanitary laboratory services within easy reach of every section of the state. Nearly one million

tests are performed annually in these six laboratories. Local public health, hospital and privately operated laboratories are also encouraged and assisted in every way possible. Some of the more important activities through which this assistance is rendered are:

(1) An evaluation and consultation program which check-tests the performance of more than 600 laboratories in the state and aids in the solution of a great variety of their operational problems.

(2) Training programs and seminars, both in the field and in state laboratories, to acquaint local laboratory workers with new or improved methods.

(3) Reference service which permits other laboratories to submit any problem specimens which they are unable to diagnose completely.

New responsibilities assigned to the Department's laboratories by the 1963 legislature include:

(1) Establishment of a laboratory service for the diagnosis of phenylketonuria.

(2) Registration of all clinical laboratories in the state. A separate bill provided for the appointment of a commission which is expected to determine whether an evaluation program or other services by this Department are needed in order to standardize the performance of these laboratories at a higher level.

At the end of 1963 both of these programs are well under way.

Milk Control

Illinois fluid milk supplies continued to be of a high safe quality, and were available at reasonably low prices. During the past biennium the trend toward fewer dairy farms, higher-producing dairy cows, and increased milk production continued. The Department continued its mandated program for animal disease control, improved milk harvesting methods, and new processing safeguards. Program adjustments were made to coincide with trends guaranteering a safe wholesome milk supply for Illinois milk consumers.

During the 1963-65 biennium, reorganization is planned to coordinate and develop a uniform enforcement program. This reorganization will include the active administration and enforcement of additional legislative responsibility covering the transportation and distribution of Grade A milk and milk products. Continued support will be given to certification programs permitting the free flow of wholesome milk supplies interstate.

Environmental Health

The administration of laws pertaining to the control of environmental factors affecting the public health constitutes an important portion of the Deparment's activities. The bacteriological safety of 1,438 public water supplies is the responsibility of the Department. Approximately 99 per cent of the urban, and 83 per cent of the state's total population, are served by public water supplies. Each of the 1,164 public swimming pools in the state are also inspected and approved by the Department.

Abatement of stream pollution, insect and rodent control, inspection and licensing of more than 700 trailer coach parks and certain migrant labor camps all come within Department jurisdiction. Many educational and training programs are carried on by the Department to improve the competency and skills of persons engaged in various occupations concerning environmental health.

Radiation surveillance of state waters and of the Illinois atmosphere continues on a 24-hour basis. Nuclear fallout monitoring stations are located in Springfield, Metropolis and Channahon. Administration of the Radiation Protection and Registration Act has resulted in the inspection and registration of almost 8,000 radiation installations in the state, including medical, dental veterinary, industrial, educational and research establishments that use one or more kinds of x-ray machines or radioactive materials. All medical radium sources registered with the Department have been inspected and checked for leakage. Earmarked for future development is the acquisition and operation of a site for the concentration and storage of radioactive waste materials.

Dental Health

Since dental health, an integral part of total health, it is also a concern of the Department. The Department promotes the fluoridation of public water supplies.

A two-year demonstration dental care program was carried out to determine the percentage of nursing home residents who need, and are willing to accept, dental treatment.

Another research project involved maintaining good oral health among mentally and physically handicapped children in Sangamon County.

An extern program, whereby four graduates will receive an on-the-job training course in dental programs conducted by the Department, has begun.

Tuberculosis Control

The Department conducts programs in case-finding by repeated x-ray surveys throughout the state, providing hospitalization for tuberculous individuals at one of the two state sanitariums, granting subsidies to those sanitarium boards unable to hospitalize all of their cases with local funds, and providing nursing consultation to local health departments and nurses employed by tuberculosis sanitarium boards and tuberculosis associations.

The Mt. Vernon State Tuberculosis Sanitarium, in conjunction with the local city school system, continues its school for practical nurses.

The Chicago State Tuberculosis Sanitarium performs all thoracic surgery required by patients in the various institutions which are administered by the Department of Mental Health. This sanitarium also offers experience in communicable disease care to student nurses from several Chicago hospi-

tals. It is now in the process of establishing an exchange visitors program, in which training in tuberculosis nursing will be given to students from foreign countries.

Plans have been completed for an extensive statewide tuberculin testing program to be expedited with the cooperation of local health agencies and associations. Three hypospray jet injectors have been acquired to facilitate mass testing. Two pilot studies, involving 10,000 children, have been completed. It is anticipated that 100,000 school children will have been tuberculin tested during 1964.

Future plans include emphasis in tuberculin testing in the pre-school age group, and in grades one, five, and nine. X-ray surveys will continue to be refined, selecting population groups at greatest risks. Evaluation of excess beds in various sanatoria throughout the state continues. This is an attempt to arrive at some plan whereby a number of currently poorly used institutions may be closed entirely.

Hospitals and Chronic Illness

Degenerative diseases of special concern to the Department include cancer, diabetes and heart disease—all leading causes of death.

Besides professional and lay education regarding heart disease, the Department distributes penicillin and other prophylactic drugs to help prevent recurrent attacks of rheumatic fever. More than 14,000 persons who receive continuous medication are listed on the rheumatic fever registry.

The Southern Illinois Cardiac Work Evaluation Unit is a new demonstration project which the Department supports. A medical analysis made at the Unit determines the physicial capacity and work potential of cardiovascular patients. This analysis helps the physicians to decide when and if the patient can be returned to a useful life. Patients are drawn from a 33-county area.

The Department actively encourages and supports early diagnosis and treatment in cancer-detection and diabetes-detecting clinics on local levels.

Inspecting and licensing hospitals in the state involves about 300 institutions. The Department also administers the Federal Hospital Construction Program (Hill-Burton) in Illinois. Under this program construction grants are given to communities to assist in acquiring needed medical care facilities. In addition, the Department administers the Public Works Acceleration Act, which provides federal grants to eligible projects in certain areas having substantial unemployment and economic problems.

The federal Hill-Burton construction allocations during 1963 totaled $7,365,195. These were granted to some 20 construction projects of medical facilities in the state. Total construction cost is estimated at $30,000,000.

In addition, under the Accelerated Public Works program, 12 projects involving hospital and medical care facilities were developed. These projects have a total construction cost of about $10,960,000 with eligibility of about $5,404,500 of A.P.W. funds.

Attempts to make chronic disease victims and the aged more useful and independent are of increasing concern to the Department. Outside of hospitals, the chronically ill receive considerable help and guidance from public health nurses. All phases of nursing care service in the home have been accented and improved.

Chronic illness, however, is not confined to the aged. For example, bronchial asthma strikes all ages, even children. During 1962, 222 deaths were caused by this disease. In 1950 there were 256 such deaths.

Chronic bronchitis and emphysema—both diseases of middle and old age—accounted for 120 deaths in 1950. They took 698 lives in 1962. The number of deaths from all three above-mentioned chronic diseases jumped from 376 in 1950 to 920 in 1962. This represents an increased death rate of from 4.4 per 100,000 to 8.9 per 100,000. In comparison, the 12th cause of death in 1962 was hypertension without mention of heart disease, with 924 deaths.

Workshops for food service personnel and administrators of nursing homes and homes for the aged are provided by the Department. These are held in various parts of the state for the convenience of participants. This program is designed to improve the quality of the food being served in the almost 1,000 licensed homes in the state.

Local Health Services

Many of the Department's activities are carried out in cooperation with local authorities. In addition to the five regional offices of the Department, 30 counties have formed their own local health units. This program is vigorously encouraged and supported by the state Department. One additional county will have its own health department in early 1964.

One of the Department's responsibilities in Civil Defense is organizing and promoting the Medical Self-Help Training Program on a state-wide basis. At the end of 1963, the program had expanded to 99 counties. About 10,000 persons had been trained, and two television series were developed. Goal of this program, started in 1962, is to teach one member of each family in the state how to care for themselves in the event of widespread disaster until medical help is available, perhaps for as long as two weeks. This means that approximately three million persons should receive such training.

The Department administers grant-in-aid funds to full-time local health departments. This policy tends to strengthen and promote public health services. Beside the 30 counties covered, there are 11 full-time city and local health district departments. Approximately 72 per cent of the Illinois population is covered by full-time health departments. However, if Chicago and Cook County, are

excluded only 43 per cent of the state's population has such coverage.

Public Health Nursing

Department programs for disease control and preventive health services are concerned with individuals and families. Public health nurses carry a heavy responsibility for implementing these programs in the local health department. Assistance and advice from the Department of Public Health Nursing Consultants, of course, given them. The problem is that there are too few nurses to provide these needed services. There is no nursing service that can be responsive to the various public health nursing needs in at least 71 counties. Nurses employed by the counties have limited and sharply-defined responsibilities. These include services to diagnosed tuberculosis patients and to school children.

In most instances there has been insufficient planning, organization and staffing of public health nurses for new programs. For example, home care programs are a major program concern in aging and chronic illness. Yet, in 76 counties in Illinois, not one nursing-care-of-the-sick-at-home program is not available.

The public health nurse carries out her responsibility by means of:

(1) Skilled observation of people in the home, the school, and in the office.

(2) Observation of factors such as significant symptoms (the expectant mother who is dizzy, edematous, complaining of headache), and observation of reaction to drugs.

(3) Observations of factors relating to health, including the family's attitude toward a disease or condition, their understanding of the physician's treatment, or their understanding of adequate nutrition.

(4) Providing nursing assistance, under medical direction, to those sick or disabled at home. Also, helping family members to provide care.

(5) Counseling families and groups in ways to foster their ability to cope with their own problems and to become more self-directing. Group experience for expectant parents is one example of such counseling.

(6) Helping families learn how to cope with problems of the retarded child, the failing older person, or the cancer patient.

(7) Administering and interpreting treatments, diagnostic tests, or carrying out investigations.

The public health nurse may be the only health worker the family sees. The quality of the public health nurse's skills and abilities has a major influence on the Public Health Program as a whole.

Illinois must greatly increase its force of generalized public health nurses to meet the emerging needs in public health.

Franklin D. Yoder, *Director of Public Health*

Appendix B

ILLINOIS DEPARTMENT OF MENTAL HEALTH

When a new Department of Mental Health was established in Illinois, Dr. Francis J. Gerty became its first director. He pioneered the new mental health program which is even now being carried forward. Immediately after Dr. Gerty's retirement, I inherited a highly organized program which was administered by an effective, seasoned team of professionals.

One phase of this program is centered around construction of new facilities. The construction phase of the Illinois Mental Health program will begin to reach its peak during the coming year. The Department will therefore intensify its efforts toward obtaining qualified personnel to staff these new facilities. The Department will also work closely with the medical profession in (1) planning the use of the new Zone Centers, and (2) working toward a meaningful collaboration in carrying out the provisions of the Mental Health Code.

We respectively request that the House consider providing space in its monthly journal for concise summaries of Department of Mental Health activities.

Zone Mental Health Centers

One third of the 1960 Bond Issue Funds was set aside for the construction of six Zone Mental Health Centers. The Department of Mental Health was moving carefully in its planning of these modern, comprehensive treatment centers.

The following list stipulates the locations of the Zone Centers and when the land tracts on which they will stand were obtained. The list also cites the pioneers in Illinois mental health history for whom the Centers have been named.

Rockford Zone: *H. Douglas Singer Zone Center.* A tract of 99.8 acres was purchased on April 5, 1962.

Chicago North: *Charles F. Read Zone Center.* On January 26, 1962, 66 acres were designated for this center.

Chicago South: *John J. Madden Zone Center.* This plot occupies 31¼ acres on former property of Hines V.A. Hospital in Maywood. This zone center will have access to V.A. facilities, and also to Loyola University's new medical center, which is located on adjacent land.

Peoria Zone: *George A. Zeller Zone Center* is on 66 acres purchased March 1, 1963.

Springfield Zone: *Andrew McFarland Zone Center* is located on 100 acres declared surplus by the federal government.

Champaign-Decatur Zone—Decatur (Adult Facilities): *Adolph Meyer Zone Center.* Through their Mental Health Association, the civic minded residents of Macon County donated 89.6 acres to the state on January 2, 1963. **Champaign (Children's**

Facilities): *Herman M. Adler Zone Center.* This comprizes 27 acres adjacent to the University of Illinois Campus.

At each of these first six zone centers a full range of treatment for both in-patients and out-patients. will be offered. Out-patient psychiatry will be emphasized at each of the zone centers. However, no distinction will be made in the quality or extent of care between out-patients and those at the clinics.

Each zone center will provide six in-patient categories of services and the following proposed allocation of patient beds:

Adult General Psychiatric Patients	170 beds
Geriatric Patients	20 beds
Alcoholic and Drug Addicts	20 beds
Adolescents	20 beds
Mentally Retarded Children	30 beds
Emotionally Disturbed Children	20 beds
Total	280 beds

Construction Schedules

Construction of the Read Center in Chicago and the Meyer Center in Decatur are underway. The timetables for construction and completion of these projects are:

Rockford: Construction, which should begin about the last week of July should be completed by March 1966.

Chicago North: Construction began last July. Spokesmen for the architects claim this center should be completed by the end of the year. This will be the first center completed.

Chicago South: Bids were taken on February 11, 1964. Construction, which should begin by mid-April, will be completed by mid-December of 1965.

Peoria: Bids will be taken in May. Construction should begin in August. This center should be ready sometime late in April of 1966.

Springfield: Construction to begin about May 18. Construction should be completed sometime in January of 1966.

Decatur: Construction began February 25, with completion sometime in October, 1965.

Champaign: Bids will go out about the 15 of April. Construction will begin about mid July, and should be completed in mid March of 1966.

Two Children's Centers

Two children's centers for the mentally retarded are being built in the southern third of the state. These are the Warren G. Murray Center, at Centralia, and the A. L. Bowen Center at Harrisburg. These centers will provide more than 1,000 beds, thus reducing the waiting lists at Lincoln and Dixon State Schools for the Mentally Retarded. They will also serve as important training and research facilities. In addition, some 72 building projects are under way, or are in late planning stages at all of the state's existing institutions. These projects will be financed by $100 million remaining from the bond issue.

Treatment Philosophy

The architectural design of each center will reflect these seven principles of a patient-centered treatment program:

1. Whenever possible, treatment should be made available within the community.
2. Facilities should provide early, intensive treatment to avoid hospitalization.
3. If the patient's treatment calls for techniques that are available only in a hospital setting, hospitalization should take place in or near the person's community.
4. During the patient's hospitalization, special programs should be initiated and oriented toward the patient's family, relatives, friends and employer. In the case of children, such orientation should be directed toward school officials, and should focus on what should be done when the patient returns to the community.
5. Out-patient care should be provided after any acute episode to hasten the patient's resumption of full community living.
6. A wide range of services should be incorporated, so that all types of psychiatric patients can be treated.
7. In a truly community-oriented program, full inter-agency cooperation is mandatory to support the therapeutic program.

Zone Directors

The zone director in each of the state's zones will plan and implement this new treatment program under the general direction of the Director of Mental Health. Since much of the initial effort in intensive treatment has taken place in the state's existing hospitals, one of his major functions will be to see that the clinic serves both the community in general and state hospitals within the zone.

In effect, Illinois is setting up individual mental health authorities for each of its eight zones of the state. They will, for the most part, function autonomously—with the Department promoting and supporting their growth through staffing, financing and administration. The zone centers should prove to be examples of good treatment programs and sources of encouragement for establishing additional community facilities supported by local governments and private agencies.

The centers will enable the Department to better exercise its functions of inspection and licensure, to provide consultation, to encourage the establishment of psychiatric units in general hospitals, and to provide extension services through branch clinics within the zone.

Since it will be physically impossible for the zone centers and other state facilities to provide all of the mental health services needed in a whole zone, the zone director will depend upon the community's skills, talents and facilities to support the treatment program.

Because of the strides taken thus far, Illinois

now ranks with the leading states in defining the state's role for extending services to communities. As this program begins increasing the mental health budget, staffing the centers, and gaining community support become critically important factors.

Appropriations

During the 73rd General Assembly the legislature increased the Mental Health's biennial appropriation by some $50 million. This represented the largest budget in the department's history, and also its most substantial increase.

The appropriation figures are as follows:

Biennium	*Department Appropriation*	*Mental Health Fund*
1961-1963	$206,624,840	$26,181,563
1963-1965	251,471,935	31,823,205

Appropriation Increases:

Department	$44,847,131
Mental Health Fund	5,641,642
Total	$50,488,773

These increases will enable the Department of Mental Health to hire additional personnel, ranging from psychiatric aides to psychiatrists. They will also enable the Department to provide more intensive patient care in the State's seriously under-staffed mental hospitals and schools for the retarded.

While these increases are substantial they cannot provide adequate care.

The Final Report of the Joint Commission on Mental Illness and Health called for tripling expenditures for public mental patient care in the next ten years.

Increasing the Department's 1961-1963 biennial appropriation by 20 per cent for the next four biennia is the goal of the Department of Mental Health. At this rate, Illinois would be able to provide care on a per capita basis ranging between $10 to $12 per day. This is a minimum cost for adequate care in public institutions today. However, it is below the per capita costs of private or VA hospitals. With continued understanding and support from both the executive and legislative branches of state government the goal can be reached.

Legislation

During the January to June session of the 73rd General Assembly a number of major legislative pieces were passed. Included are some highlights:

SMs 293 through 312 and HBs 236 through 256 separated services for children and non-mental health facilities from the Department of Mental Health. The bills created a new Department of Children and Family Services and a new Commission on Children. They also amended the Civil Administrative Code.

HBs 708 and 709 encourage early treatment of mental illness in the community. Local governmental units are authorized to construct, operate, and maintain community mental health facilities and services—including services for the mentally retarded. Provision is also made for the Director of the Department of Mental Health to make grants-in-aid to units which establish such facilities. Provision is also made for an annual tax limit of 0.1 per cent upon approval of the electorate.

HB 392 amends the present plan regarding payment for patient care. Major changes provide that patients and their estates are to be liable for actual per capita cost of care. Charges against liable relatives are established collectively at a maximum of $50. Liability is limited to 12 years. Charges for the care of mentally retarded children between the ages of six and 17 are re-established.

HB 394 revises statutory provisions for Department assistance to families with mentally retarded children who are in private licensed facilities and who are on waiting lists for placement in state facilities for the mentally retarded.

HB 1578 requires the Department of Public Health to conduct an intensive educational program concerning phenylketonuria (PKU) in order to seek means of preventing this one cause of mental retardation.

SB 861 authorizes county and multiple-county Public Health Districts to establish mental health programs and services—including services to the mentally retarded which are "not inconsistent with the regulations of the Department of Mental Health."

SB 923 permits the construction of seven regional office-service buildings by the Illinois Building Authority for use of certain state departments and agencies, including the Department of Mental Health.

HB 385 names new zone centers and children's centers in honor of pioneer leaders in the mental health movement in Illinois.

HB 393 gives the Department power to close a licensed mental health facility that jeopardizes patients' welfare by violating rules or regulations.

HB 1416 makes privileged the communications between patients and their psychiatrists.

New Mental Health Code

HB 918 established a New Mental Health Code, effective July 1, 1964. This Code has four broad purposes:

Informal Admission: Article IV of the Code adds a new form of voluntary admission which is called Informal Admission. Under this form any person may go to a state hospital and request care and treatment without signing any formal admission papers. He may also—without obligating himself—remain as a patient for any definite length of time. If the superintendent determines that this person can benefit from the hospital's services, the person will receive care and treatment as long as he remains in the hospital. He will be free to leave

at any time.

Admission on the Certificate of One Physician: Article VI adds another new form of hospital admission. The hospital superintendent may receive —and detain as a patient—any person alleged to be in need of mental treatment and suitable for care, but who does not object interested person's application which is accompanied by a physician's certificate that has been executed within ten days prior to admission.

If at the end of 15 days a patient hospitalized under a one physician certification does not agree to become a voluntary patient, a second physician's certificate may be filed with the hospital. This changes the patient's status to that of a patient hospitalized under Article VII on the certification of two physicians (*see below*).

Hospitalization on the Certificate of Two Physicians: Perhaps the most important admission procedure added to the new Code allows persons in need of mental treatment to be hospitalized involuntarily upon application plus the certification of two physicians. The twofold legislative purpose underlying the two-doctor involuntary certification eliminates the need for court proceedings in cases where the patient or any other interested person does not request them. It also allows hospitalization and immediate treatment to begin before any court proceedings that may later be requested or required begin. Article VII requires that the need for hospitalization be confirmed by the receiving hospital immediately upon admission.

Protection of the Patient: Once a patient is hospitalized under Article VII, a full range of procedural protections comes immediately into play. These protections assure that the patient's basic civil rights are in no way abrogated or diminished. Within twelve hours of admission, a notice which describes in clear and simple terms the patient's rights under the Code must be furnished to the patient as well as to his parents, children, spouse, other nearest relatives or other persons designated by the patient. The notice and explanation of rights must be written in a language known to the patient. If the patient cannot read, the notice be read to him.

As a further protection, Article VII provides that within five days of admission a magistrate or judge shall consult with the patient and explain his rights under the Code. These rights include fair notice to the patient and others concerned with his welfare, an immediate court hearing with a jury trial if such is requested, counsel, and judicial review, if this is necessary.

In addition, the present Code's procedures for discharge petitions and habeas corpus are preserved. So are the present methods of hospitalization—voluntary (Article V), commitment upon court order (Article VIII) and emergency (Article IX).

At present, the Department is developing programs to provide physicians from psychiatric divisions of the courts, the state hospitals, state medical and psychiatric societies, or other county and local medical facilities who will make examinations and execute certificates when necessary.

Planning Division

Illinois has progressed farther than any other state in designing the state role for the extension of mental health services to communities through its zone center plan. A soon-to-be-developed Division of Planning within the Department will be of inestimable help in furthering this total program. In July, the Department of Mental Health received a $171,000 grant from the U.S. Department of Health, Education and Welfare for comprehensive planning. This grant will permit us to begin such planning with the communities we seek to serve.

Serving under the Planning Director will be two assistants, a statewide planning director and one for the Northeastern Metropolitan Area. To assist them, our staff will include a chief of data collection and analysis, a chief of field services, a chief of program and liaison, and a communications specialist.

Advisory Groups

An eight member Planning Board will serve as an advisory group to the State Planning Director. Under each assistant planner—statewide and northeastern metropolitan—will be four planning councils. These will be the Zone Committees; local, state and federal agencies; professional societies; and citizens' groups.

Restricting our attention to the Northeastern Metropolitan Area planning councils, this is what the membership of these groups will be like:

1. *Council of City and County Agencies.* These include health organizations; psychiatric diagnostic facilities; planning groups; and organizations concerned with education, safety, youth delinquency control, human relations, public works, public aid; and, finally the courts.

The principal function of each organization would be to review its relationship to mental health in Illinois and to make their personnel and data available for special projects. Most important, such agencies would provide not only a line of communication, but also a heretofore untapped source of expertise in relating their own field to mental health.

2. *Council of Professional Societies and Organizations.* This would include membership of professional group associations and societies in these areas: Medicine, Law, Teaching, Hospital Planning, Welfare, Psychology, Social Work and others. These knowledgeable and expert specialist groups would be available for special projects.

3. *Council of Citizens' Groups.* This would include board members of citizens' groups interested in mental health. Among these would be the PTA, labor, veterans' organizations, chambers of com-

merce, taxpayers' federations, political organizations, Jaycees, NAACP, Urban League, National Conference of Christians and Jews, plus the Mental Health Society of Greater Chicago and the Chicago Council for the Mentally Retarded.

4. *Council of Universities and Training Institutes.* Numbered in the membership of this council would be the major universities in Chicago, the medical schools, and the various facilities for training in psychiatry.

In all of this organization, both statewide and in the Chicago metropolitan area, we have purposely planned for considerable overlapping. It will serve the desired effect of keeping all committee members informed of the state's mental health problems and progress.

Summary

In this report we have summarized the progress and philosophy of the Department of Mental Health's Zone Center program. We have also noted progress in the area of mental retardation. A report on appropriations for the 1963-1965 biennium, Mental Health legislation, the state's new Mental Health Code and the Department's Division of Planning are also included.

Harold M. Visotsky, *Director,*
Illinois Department of Mental Health

EXECUTIVE ADMINISTRATOR

Each year it becomes increasingly more difficult to determine which specific items pertaining to ISMS affairs should be included in my written and oral reports to the House of Delegates. Hundreds of such items could most certainly be reported upon if sufficient space were available to contain the data, and if we had unlimited time to prepare the detailed presentation that would be required to hold such data. Adequate time and space are not, of course, at our disposal.

Previous reports submitted by the Executive Administrator have dealt with such topics as staff organization and the general philosophy of medical society management. Last year's report discussed the broad objectives and general planning activities of ISMS. This year I have decided to be more specific in the area of describing the functions that have been assigned to the Executive Administrator.

A major portion of my time is devoted to planning. This includes the planning of major meetings such as those of the House of Delegates and the Board of Trustees. It also takes in the organization and supervision of various key committee activities.

My planning functions are by no means confined to top-level committee activities and meetings, however. Ideas and plans submitted by the staff must necessarily be reviewed for administrative strengths and weaknesses. Such ideas and plans are thoroughly studied and discussed.

The weekly staff conferences are especially fruitful. It is here that details of planning by staff members are evaluated and integrated with the plans of other staff members and also other committee activities. Minutes of every such meeting are recorded for filing, appropriate follow-up, and subsequent discussion. Copies of these minutes are made available to the Chairman of the Board of Trustees and to the President. These minutes are available to the reference committee for review.

Staff Planning

The development and implementation of plans provide the backdrop for the major portion of all staff activities throughout the year. For more than three years, I have had advance notice of all important staff needs, and I have coordinated the personnel and resources that were deemed necessary to the successful accomplishment of their assigned tasks. These resources and personnel have, on occasion, been shifted to different staff directors in order that some otherwise impossible project might be successfully completed. For example, during the two months preceding the Convention, priority for reproduction and multilith work is granted to the preparation of materials for the House of Delegates, to scientific programs, to announcements of meetings to be held during the convention, and to important information destined for the Board of Trustees. Although materials are also turned out for routine committee projects during this time, these must obviously be given a secondary priority.

Implementation Schedule

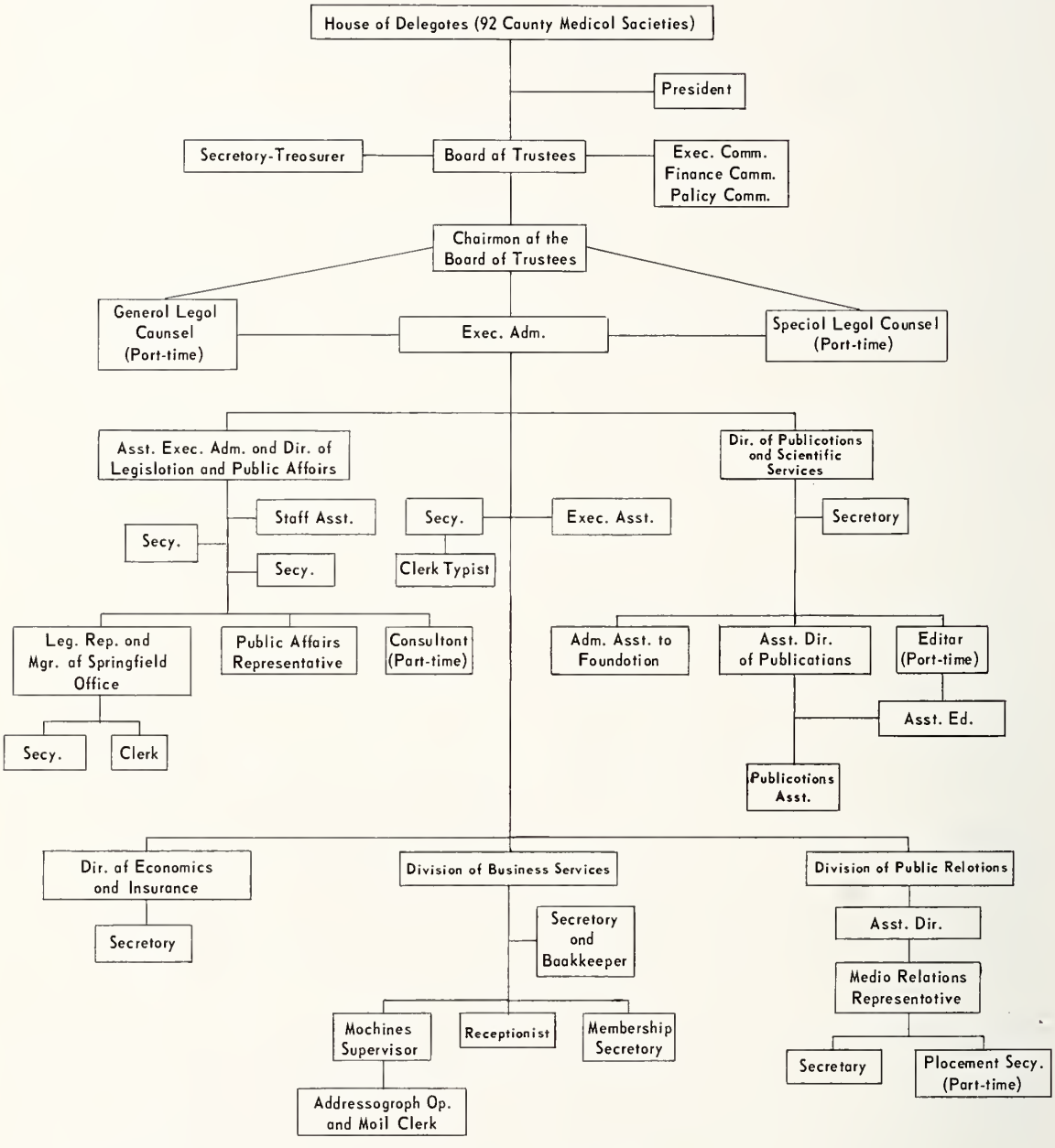
The planning function of staff is so important that we now project our planning on a four month basis in order to insure adequate service and correlation of work. We call this our *implementation schedule.* Here is an instance that might give you some idea of how this schedule operates: A compilation of listings by the Division Directors covering important deadlines and projects to be completed between January 1, and May 15, required over 30 pages—each of which contained 15 to 20 items. If desired, this listing will be made available to members of the reference committee.

1964 Staff Chart

Attached to this report is a chart of staff and personnel of the Society—both full and part-time. Full-time personnel has been increased by two since the last meeting of the House of Delegates. This is because the Board of Trustees authorized an increased activity in the area of Public Affairs which required two additional persons to implement its program. A more complete report on how this affected the 1964 budget will be discussed by the Chairman of the Finance Committee, and other officers.

ISMS STAFF ORGANIZATIONAL CHART

(As of January 1, 1964)



29 Full-time Employees 1 Foundation Employee 5 Part-time Employees

Position Descriptions

Position descriptions are available for each job title which appears on the chart. More detailed functions are frequently added to an employee's responsibilities. Seldom, however, are we able to eliminate functions. As committee activities continue to increase, and as new projects are added, the implementation of more work must be continually refined by more clearly defined methods. In the next six months it is planned that each permanent project will be carefully outlined in a project manual. For example, Mrs. Zimmer has prepared most of the material for the House of Delegates for many years. She begins this work at least five months in advance of the meeting. How and when she prepares this material will be carefully listed so that any unnecessary steps can be eliminated, and any improvements be included.

It might be noted that Mrs. Swanson, who serves as the Secretary for Physicians Placement, has her project carefully outlined and all procedures listed. This manual would make it possible for any secretary in the office to carry out this function in the absence of Mrs. Swanson. Thus it is important that the project outline be available for training and orientation purposes in the event that personnel changes are made or duties transferred. This process not only makes for more efficient training, but it also provides a check on how adequately the work is accomplished, and the full duties of all personnel.

What Do We Do?

Sometimes I am asked the question: "What do you and your employees do?" Actually this question is not difficult to answer if I can have an hour of the questioner's time. In that interval, I can present some specific examples. Lacking this much time, however, I thought I would attempt to merely touch upon some of the important projects which the staff has accomplished during the past year, and some that are being worked on at the time this report is being prepared.

Preparation for Committee and Board Meetings

An efficient administrator is always adequately prepared for meetings. To insure such efficiency, we have assigned a staff member to each committee of the state society. His function is to serve the committees to which he is assigned in a manner that is consistent with standards establshed by the chairman. The staff committee member devotes many hours to preparation—even before a committee meeting takes place. He discusses problems on the agenda with the committee chairman. Research into each subject to be discussed is performed. Thus, information is made available to everyone connected with this committee's project.

After a meeting the staff member performs follow-up functions such as preparation of minutes, correspondence, and reports to the Board of Trustees. At the close of the year, a report is made to the House of Delegates. Should the House of Delegates concur with recommendations, or suggest project implementation, then the staff member pursues that particular endeavor—perhaps for several years, and it becomes another routine responsibility.

When I was in the Armed Services, and later teaching school, it was not unusual to spend several hours in preparing for one hour of lecture. Much more preparation time is required, however, for meetings with committees. Thus with more than 60 committees meeting continuously throughout the year, literally thousands of staff man-hours are given over to preparation, attendance and follow-up on committee meetings alone.

All staff members are in some way involved in the presentation of materials and reports to the Board of Trustees. For several weeks prior to a Board meeting, staff work is so correlated by me that ten days before the meeting takes place a complete agenda is prepared and mailed to all concerned—including the finance, executive and other committees which usually meet just before the Board of Trustees. Words cannot describe the magnitude of this preparation, but the Board of Trustees can attest to the efficiency, adequacy, and timeliness of our staff presentations.

Field Work, AMA, District and County Society Meetings

A complete report of all field services is not available because it would require considerable research prior to the publication of this report. However, most of these are noted on an integrated weekly schedule which provides me with all information on the whereabouts of all staff members. A compilation of these schedules will be available for review by the reference committee if they so desire.

Attendance at AMA meetings requires considerable staff attention and time. For two weeks per year certain members of the staff prepare materials for the delegation, arrange for and attend pre- and post meetings, review all actions of the AMA and correlate them with state society programs, attend meeting of the Medical Society Executives Association as post-graduate courses, and finally, they assist in the preparation of reports by members of the delegation.

District meetings are held by each trustee throughout the course of a year. Meeting notification, preparation, travel, and minutes require staff time. Principally coordinated by me, these meetings provide the follow-up for trustees to discuss their problems with delegates from county societies. They also provide grass roots opinion for trustees to report to the Board. More and more time will probably be devoted to these meetings in the future.

Attendance at county society meetings by staff is not on a regular basis. However, specific problems frequently arise which make it possible for the staff to render valuable services. We encourage

county societies to call upon us and we have arranged for at least one staff member to be present whenever we are called upon. Under these circumstances an estimate of time given over to field work is not easy to provide. However, in no instance known to me have we ever been called upon and failed to provide the field service requested.

Staff members also spend hundreds of hours meeting with representatives of other groups such as the administrators of voluntary health agenices, other professional societies, governmental agenices, staff of the AMA, and trade associations. All of these contacts make it possible for us to provide a broad base for telling the public and other groups about the activities of ISMS. Not the least of these contacts are with members of the Illinois General Assembly, representatives in the U.S. Congress, and other national associations and agencies of the government.

Specific Accomplishments and Tasks

During the past year staff has implemented hundreds of projects. Some of these projects deserve to be described in detail. However, space does not permit this. I am therefore listing herein some items which were staff implemented since the last meeting of the House of Delegates (If more explanation is required on any item I will be present at the reference committee to provide the details).

(1) Follow-up on actions of the 1963 House of Delegates, including preparation of abstracts, numerous reports to the Board of Trustees, referral and discussion with committees, and dissemination to the membership and appropriate groups affected.

(2) Preparation for five meetings of the Board of Trustees and of appropriate minutes and abstracts for publication and dissemination, and follow-up on an average of 40 important actions, including appropriate publicity.

(3) Arrangements and preparations for more than 60 committee meetings, each of which convened about three times. Minutes were kept, appropriate follow-up was expedited, and approved projects and actions were implemented.

(4) Preparation for and attendance at two AMA meetings. This included arrangement of details discussed previously in this report.

(5) Close supervision of all fiscal policies established by the Finance Committee. This included payment of all bills, and the submitting of a monthly financial statement. It also included maintaining the established budget, conserving funds where possible, and preparing a proper accounting of all Society financial responsibilities, such as the Benevolence Fund, the Educational and Scientific Foundation, AMA-ERF funds, etc.

(6) Employment and training of new employees, as well as replacement of those who resigned or were dismissed. This, of course, includes proper search for new employees, and careful interviews of candidates.

(7) Preparation and refinement of letters of appointment for all committee members after approval by the Board of Trustees. Exceeding care is taken so that all committees are properly informed on their responsibilities, the staff assigned, and the budget established for them.

(8) Compilation and publication of the Constitution and Bylaws after revision.

(9) Publication of all committee members.

(10) Preparation and publication of 12 issues of the Illinois Medical Journal.

(11) Planning and all preparations for the 1964 Convention, including the House of Delegates, Scientific Sessions, Exhibits and social affairs.

(12) Newspaper releases on all important actions of the Society, special event coverage, and some county society meetings. Regular *Safeguard Your Health* releases covering hundreds of aspects of health.

(13) Television and radio programs. These are too numerous to list here, but a summary will be found in the P.R. committee report.

(14) District meetings, not only with trustees, but also with the Auxiliary, including assistance in preparation for meetings of their Board of Directors and important committees.

(15) Review of all legislation with a medical significance into the General Assembly with a medical aspect. Follow-up with county legislative committees after appropriate consultation of State Legislative Committee and the Board of Trustees. Publication of Legislative Newsletter and preparation of abstracts for the Journal.

(16) Reorganization of staff to provide more direct supervision of staff services by the Executive Administrator. This included the establishment of a Division of Business Services, and a Division of Economics and insurance.

(17) Discussion and presentation of data on new lease for headquarters office. Renovation of present offices, and some additional low cost rented space to provide more adequate space and storage facilities.

(18) Implementation of *Operation Hometown* via establishment of county society committees, including follow-up meetings.

(19) Continuation of services of Regional Office located in Springfield.

(20) Development of projects and service to committees concerned with the Educational and Scientific Foundation.

(21) Transmission of nationwide acclaimed educational program on Medical Self Help.

(22) Research and development of basic information on the preparation of a Policy Manual.

(23) Establishment of a photo and art work file for future use in preparation of printed materials and publicity.

(24) Editorial work on a manual for Medical Society Executives, underwritten by the AMA through the Medical Society Executives Association's Committee on Continuing Education.

(25) Establishment of a file on previous and cur-

rent legal opinions for referral to county medical societies upon specific request. Review by legal counsel of various activities of committees to ascertain the correct legal procedure to be used.

(26) Preparation and distribution and publication of special materials on the Kerr-Mills program, the Relative Value Study, the Drug Formulary, and the Manual for County Committees on the Aging.

(27) Implementation of a new Public Affairs program, including attendance by 65 physicians and their wives at the Public Affairs Conference of the U. S. Chamber of Commerce.

(28) Close staff supervision of development of the Health Careers Council, and attendance at all meetings with the Society's representative.

(29) Close liaison with the Medical Examining Committee, the Department of Registration and Education, the Department of Public Health, the Department of Mental Health, and the Department of Public Assistance.

(30) Preparation and implementation of a meeting with the Deans of Medical Schools on problems of mutual concern and interest.

(31) Preparation of testimony before the House Ways and Means Committee on the King-Anderson Bill; also to the Internal Revenue Service on the Incorporation Act.

(32) Continuation of Physicians Placement Service.

(33) Financial control and supervision of student loans, including interviews and periodic consultations with students.

(34) Continued provision of scientific speakers for county medical societies and post-graduate courses when requested.

(35) Provision of speakers on all types of subjects—particularly on national legislation to associations, groups, schools, service clubs, etc.

(36) Initiation of new dues forms for county societies, membership records and AMA-ERF contribution designations.

(37) Preparation for special meetings such as Conference of Committee Chairmen, Secretaries' Conference, Conference with County Medical Society Executives, voluntary agency administrators, presentation of awards, etc.

(38) Preparation of *White Paper* on driver licensure.

(39) Continued implementation of IMT program in co-operation with the courts and preparation of two year report on results to date.

(40) Participation in Association program at U.S. Chamber of Commerce, and attendance at committee functions. Advancement of county society and individual participation in Chamber activities.

(41) Implementation and executive services to the Illinois Association of the Professions.

(42) Participation in programs and committee services to the Associations Executive Forum of Chicago, the American Society of Association Executives, the Medical Society Executive Association, etc.

(43) Preparation of packet to be distributed to each new member of ISMS.

(44) Preliminary preparation of the publication of a Membership Issue of the Journal, which will contain much valuable organization information to all members.

Remarks

This listing contains only a small number of the projects that were expedited by ISMS staff during the past year. If we were able to include detailed descriptions of everything that the staff does in behalf of the Society and of ISMS membership, the Executive Administrator's report would take up more space than is now alloted to the entire Handbook. We do hope, however, that this summary of staff activities will give you some impression of how staff efforts and skills are combined to produce the final product—an efficiently operating Society.

Acknowledgements

In closing this report, I wish to express my deep thanks and appreciation to the personnel of our staff. My deep admiration for each and every one of our employees makes it impossible for me to single out any for special recognition. Our staff is characterized by selflessness rather than selfishness, by giving rather than by taking, by "get the job done" rather than "let George do it," by activity rather than apathy, and by a concern for the organization rather than for their individual needs.

This is not to say that all activities in our office are sweetness and light. We have our internal headaches and personal problems, but these are not without their compensatory reactions. Company these with the good will and respect which is generally inherent in our office, and I feel well satisfied with the progress that has been made during the past year. I look forward to another year of significant administrative progress.

I would like to express my especial thanks to Dr. Newton DuPuy, Chairman of the Board of Trustees. It is to him that I am most directly responsible as Executive Administrator. Dr. DuPuy has at all times been understanding, cooperative, and particularly sympathetic to all projects devoted to improving your Society.

Robert L. Richards

POLICY COMMITTEE OF THE BOARD OF TRUSTEES

The Policy Committee of the Board of Trustees (established under the Bylaws in May, 1962) presented its first report to the House of Delegates as "Appendix A" to the report of the Chairman of the Board in May 1963. This committee is working (not only under the Bylaws, but also under a directive from the House) to develop as soon as

possible, a *Policy Manual* for the use of officers, trustees, committee chairman, members of ISMS, and the staff which carries out these established policies.

In areas where no policy exists, material must be prepared. The various committees are (and have been) submitting policy statements for the approval of the House. A lengthy list of suggested subjects upon which policy might well be established will be found in the pockets presented to each member of the House. Attached to the list are several selected "policy statements" to serve as examples and to assist members of the House to differentiate between "policy" and "procedure," etc. In the various reports submitted by the committee chairmen, requests have been made for approval of policy statements.

As a definite policy request from a specific committee comes before the House and is approved, the Policy Committee will "lift" this statement from the actions of the House, and incorporate it in the manual. Therefore, even though the report of the Policy Committee comes before the Reference Committee considering the reports of officers and trustees, we will confine any request for policy approval to subject matter which pertains to the general activities of the Board and the officers of the Society.

As time goes on, this material will accumulate, and the Policy Committee easily can assemble the statements made by the various reference committees and approved by the House, incorporate those which pertain to "policy" and update the manual following each session of the House.

The chairmen of all committees have been asked to list as a part of their annual reports this year, the policy statements on which they desire House action. By official vote the House may:

(1) Approve, reject or amend the proposed policy

(2) Order it referred to the Board of special study

(3) Refer it back to the Committee for additional consideration and subsequent report.

The Policy Committee sees no way in which a finished product can be developed short of several years of work. A superficial check has been made into the minutes of the House for the past ten years, and now the committee needs the close and sustained cooperation of the officers, trustees, committee chairmen, members of the House and the staff directors working in these various areas.

We ask your indulgence and patience, since any compilation of material which can and will carry the impact and influence of a POLICY MANUAL must be prepared carefully by all involved. Outdated material must be eliminated; current statements must be prepared for House action; the cooperation and assistance of each individual at the policy-making level is earnestly and sincerely solicited.

Take the list in the packet prepared for the House and check it over; criticize it carefully; make changes and additions where you feel you can contribute. We hope that this material will emerge as a HANDBOOK for general use and guidance. It should reflect credit and provide recognition for your Society, as it is (as far as we know) the first time any state medical society has attempted to develop such a policy manual for its membership.

E. A. Piszczek, *Chairman*
John Lester Reichert Fred C. Endres

DELEGATION TO AMA HOUSE

The American Medical Association has sent detailed information relative to all members about actions taken by the House of Delegates, both at the Atlantic City meeting last June and at the Portland session in December. Therefore this annual report for the House of Delegates of the Illinois State Medical Society will be confined to activities in which Illinois participated.

Membership on Reference Committees and Elections—June, 1963

Walter C. Bornemeier—*Chairman*
Reference Committee on Amendments to the Constitution and Bylaws

Carl F. Steinhoff, a member of the Reference Committee on Reports of the Board of Trustees

Elections

Percy E. Hopkins (nominated before the House by Dr. Leo P. A. Sweeney as chairman of the ISMS delegation) was elected to his second term on the Board, and subsequently elected by the Board to serve as its Chairman.

Walter C. Bornemeier (nominated before the House by Dr. Burtis E. Montgomery) was elected by a firm majority to serve as the Vice Speaker of the House, and as such, he attends all meetings of the Board, including executive sessions, with the right of discussion, but without the right to vote.

Memorial Services

In 1962 Illinois delegates were among those requesting the AMA House to conduct memorial services at each June meeting for prominent physicians who have died since the last session. At the Atlantic City meeting, tribute was paid to the following physicians from Illinois:

Clifford G. Grulee, Chairman, Section of Diseases of Children, 1925-26.

Walter G. Maddock, Chairman, Section on Surgery, 1957.

Eugene T. McEnery, Vice Chairman, Section on Pediatrics 1951 & 1952; Chairman of the Section in 1953; Alternate delegate from Illinois at the time of his death in 1962.

James Herbert Mitchell, Secretary, Section on Dermatology and Syphilology 1923-1926; Chairman, 1926-1927.

Vincent J. O'Connor, Secretary, Section on Urology 1939-1941; Chairman of the Section in 1942.

J. Mather Pfeiffenberger, Delegate from Illinois, 1915, 1916; 1928-1959.

John J. Pflock, Delegate from Illinois 1933-1945.

Resolutions

(1) At the June 1963 meeting, Illinois introduced Resolution #36 (*Study and Evaluation of Toxicants*). The House referred this resolution to the Board "for further study and implementation." At the Portland meeting the Board recommended that a panel on household and economic chemicals be established under the Adverse Reaction Section of the Council on Drugs; that Poison Prevention Committees be established, or that this activity be assigned to an existing committee in the state and local medical societies; and that the related responsibilities of staff in this area be approved.

The reference committee requested that the attention of the medical profession generally be called to the necessity for reporting adverse reactions to either drugs or household and economic chemicals to the Council on Drugs in order to implement the program. Some of the members of the reference committee (those engaged in a phase of medical practice in which the toxicants and pesticides were of considerable concern), felt that experience indicated that NOT regulatory procedures, but rather extensive and continuing educational programs were needed. The reference committee was "glad to note that the emphasis of the Board's request was also in this area". . . and the House concurred.

(2) The second resolution introduced in Atlantic City was Resolution #37. It had to do with *flammable fabrics*. It, too, was referred to the Board of Trustees for "study and appropriate action." At the Portland session, the Board approved an educational program to create a public awareness of the fire hazard of clothing. Members of the reference committee were in agreement with the Board that the real solution of the problem did not rest in changing legislation—but rather in the education of the public to prevent careless exposure to combustion of commonly used fabrics. The committee recommended (and the House concurred) that such an education program to "create a public awareness of fire hazards to clothing" was needed. Co-operation with such groups as the National Safety Council, the American Academy of Pediatrics, and the Fire Protection Association was recommended.

(3) The third resolution in which Illinois was involved, was Resolution #2 introduced at the Los Angeles meeting in December of 1962, and discussed both at Atlantic City and Portland. The resolution dealt with *United Health Foundations*. Originally this resolution was referred to the Board. In Atlantic City the Board asked for additional time prior to presenting a formal report to the House, so that its deliberations might include whatever information developed at the AMA Institute held at the Drake Hotel, Chicago, in August of 1963. In Portland, the Board then recommended: (a) to establish as a sub-committee of the Committee on Voluntary Agencies, a "Committee on Continuing Professional Education Programs of Voluntary Health Agencies" . . . to co-ordinate the professional educational activities from the Committee on Voluntary Health Agencies, the Council on Medical Education and Hospitals and the national voluntary health agencies; and (b) to designate the Committee on Voluntary Health Agencies as a COUNCIL of the AMA Board of Trustees, and to transmit this requqest for a change of status, to the House of Delegates. This supplementary report of the Board of Trustees was sent to the Reference Committee on Insurance and Medical Service, and the report of this reference committee was approved by House action. It recommended:

"That the AMA maintain its policy of neither approving nor disapproving national voluntary health agencies". . ."that the AMA, through its Committee on Voluntary Health Agencies, maintain its position of offering guidance on medical aspects of national voluntary health agency programs.". . . The House also approved "The Principles of Medical Guidance to National Voluntary Health Agencies" which contain a new definition of a voluntary health agency; objectives of the Committee on Voluntary Health Agencies, and a list of suggested mutual obligations between the AMA and the National Voluntary Health Agencies. The House directed: "There should be a mutual exchange of information and opinion enabling the medical profession and the agency to understand each other's policy and practice. A national voluntary health agency should seek the advice of the medical profession when embarking on any national medical program.". . .

(4) At Portland, Illinois sponsored and introduced Resolution #21 dealing with membership of local and state medical societies in the United States Chamber of Commerce. This resolution was approved, and the Board was requested to call this to the attention of all county and state societies. This has been done, and Illinois has "followed through" with a local county medical society membership drive coordinated with representatives of the U.S. Chamber.

(5) Illinois also co-sponsored (with Texas and Pennsylvania) Resolution #1 which expressed official regret at the assassination of President John F. Kennedy, and authorizing a copy of the resolution be sent with a letter of sympathy to members of his family, by the Board of Trustees.

Membership on Reference Committees—Portland, 1963

The following members of our delegation served on reference committees at the Portland meeting:

E. W. Cannady—Reference Committee on Insurance and Medical Service.

Leo P. A. Sweeney—Reference Committee on

Amendments in the Constitution and Bylaws.

Frank H. Fowler—Committee on Credentials.

William K. Ford—Reference Committee on Reports of Officers.

Harlan English—Reference Committee on Executive Session.

Paul H. Holinger—Reference Committee on Miscellaneous Business.

(While Doctor Holinger is not a delegate from the State Society, he represents the Section on Laryngology, Otology and Rhinology in the House. He attended all meetings of the ISMS delegation, worked both in Atlantic City and Portland, and contributed materially to the success of the Illinois delegation at both meetings. It is with special commendation that we call his activities to your attention).

Other Activities

Dr. Burtis E. Montgomery, as a member of the Council on Medical Service, met with the Council during the Portland and Atlantic City meetings. Dr. Harlan English served—and is now serving—as a member of the Council on Medical Education and Hospitals. Dr. Walter C. Bornemeier was a member of the Council on Constitution and Bylaws until he submitted his resignation following his election in Atlantic City, as Vice Speaker of the AMA House of Delegates. Dr. George F. Lull is a member of the "Gunderson Committee" appointed by the AMA Board; to review the "organization of the AMA House of Delegates."

Dr. H. Close Hesseltine, together with Dr. Harlan English and Mr. John W. Neal, attended the Portland meeting of the AMA Committee on Osteopathy and Medicine, to represent our state society. Doctor Hesseltine presented a summary of this meeting to the Board of Trustees of ISMS at its January, 1964 meeting. Doctor Hesseltine also serves as a member and chairman of the newly created National Council for the Accreditation of Nursing Homes sponsored by the AMA and the American Nursing Home Association.

Delegation Activities

"Headquarters" were maintained at both the Atlantic City and the Portland meetings—a special action in 1963 because of the candidacy of both Doctor Hopkins and Doctor Bornemeier. The Illinois sponsored luncheon was held in Atlantic City, was a successful affair with nearly 500 in attendance.

No special affair was planned for the Portland meeting. The session took place such a short time after the death of President Kennedy, the members of the delegation believed activity of this type was inappropriate.

Breakfast sessions were held each morning for the members of the delegation (delegates, alternate delegates, officers of the Society and staff present at the meeting). At one breakfast meeting, Doctor Hopkins brought Dr. Edward A. Annis, president of the AMA, and the delegation enjoyed an informal meeting with him.

At the San Francisco meeting next June, Illinois will have it usual Monday luncheon on the 22nd. Letters have been sent to the Convention Services Division of the AMA requesting accommodations at the Fairmont Hotel, both for the headquarters suite and the luncheon facilities.

Grass Roots Followup

As a result of the formal notification from the AMA following the Portland meeting, a letter has been sent to all county medical society and all CMS branch society officers asking that they give serious consideration to affiliation with the U.S. Chamber of Commerce. Attached to this letter, signed by Jacob E. Reisch as secretary-treasurer of ISMS, was a copy of the POLICY STATEMENT of the U.S. Chamber relative to "Health and Medical Care." This statement should be a definite factor in influencing county and/or branch societies to affiliate and support the Chamber as a "spokesman for medicine" in the Nation's capitol.

Dr. Harlan English, as president of the Illinois State Medical Society, had the privilege and pleasure of presenting the AMA-ERF check to the president of the Foundation, Dr. Raymond M. McKeown of Coos Bay, Oregon. The check this year amounted to $186,000, which brought the total contributed through the dues structure of this Society to over $2,000,000.

At San Francisco

At the June 1964 meeting a luncheon will be scheduled on Monday; that breakfast will be held for the delegates, alternate delegates, officers and staff in attendance to provide an opportunity to work closely, pool information, make assignments among the representatives present, and to listen to daily reports; that the candidacy of Doctor Bornemeier to succeed himself as Vice Speaker of the AMA House, will be a matter of primary concern. At the present time no other Illinois candidates have been announced by the delegation to run for any elective office.

Through continuity and planning, it is hoped that a program can be developed which will reflect careful thinking and far-reaching influence. Illinois has made progress during the past few years, and hopes to continue to do so through its eleven delegates from the ISMS, and its one member of the House who represents a Section.

Leo P. A. Sweeney, *Chairman*
E. W. Cannady, *Secretary*

Walter C. Bornemeier
Harlan English
William K. Ford
Frank H. Fowler
Arthur F. Goodyear
Maurice M. Hoeltgen
Burtis E. Montgomery
H. Kenneth Scatliff
Carl F. Steinhoff
Paul H. Holinger,

Section on A.L.R.



COMMITTEES ASSIGNED TO DIVISION OF ADMINISTRATIVE ACTIVITIES

ILLINOIS ASSOCIATION OF THE PROFESSIONS

The Illinois Association of the Professions was chartered February 1964. Seven professional groups are representative members of this new association. They are: the Illinois Bar Association, the Illinois State Dental Society, the Architects Association of Illinois, the Illinois Pharmaceutical Association, the Illinois Society of Professional Engineers, the Illinois State Veterinary Medical Association, and the Illinois State Medical Society. These are the same groups whose delegates met in March of 1963, and on repeated dates thereafter.

Membership of individuals is to be urged and will be sought within the year. Medicine is proud of its companions and of the privilege of helping form this great association. In gratitude your committee comes to the Board of Trustees, the House of Delegates, and to individual members for that privilege.

The attendance of the Chairman and our Executive Administrator at the annual meeting of the Michigan Association of the Professions gave us material, ideas and program plans to be considered as a part of the Illinois Association of the Profession's future activities.

Your Chairman is justly proud and grateful for the selection of medicine's representative for chairmanship and executive secretary positions in the initial offices.

Members of our committee have been in liaison with pharmacy, with law, and with the Interprofessional Council. Representatives of our committee have attended the meetings of the Interprofessional Council. A recent significant action by the Council was to adopt a resolution brought in by members of the ISMS endorsing an educational program against smoking directed toward teenagers against smoking.

They have also decided to present the Annual Award of the Council to O. Norling-Christensen, D.V.M., posthumously for his excellent efforts in behalf of professional relations.

The Council has also heard representatives of the Department of Registration and Education discuss the licensing program, as well as the other responsibilities of the Department. It is anticipated that this kind of program will be continued in the future in order to alert the member organizations to problems immediately confronting the professional groups, and we hope to enlist the help of the five other member organizations in endorsing state legislation of advantage to all the healing professions.

George B. Callahan, *Chairman*
Charles Allison — James D. Majarakis
Andrew J. Brislen — E. A. Piszczek
Robert L. Richards, Ex-Officio

COMMITTEE TO STUDY COMMITTEES

The Committee to Study Committees has observed committee functions and reviewed the committee reorganizations as approved by the House of Delegates in 1963. Meeting on January 11, the Committee recommended to the Board of Trustees that the Constitution and Bylaws be amended by rearrangement of the Committees, placing those committees elected by the House in one section, and those appointed by the Board of Trustees in another. This would minimize confusions on election and appointment. It would also be more flexible in the event that committees are added or dropped.

The Committee to Study Committees repeats that the House of Delegates authorized certain changes in May 1963, but elected to defer implementation of those changes until May 1964. Thus the membership of the following committees will be elected at the final session of the 1964 House of Delegates: Medical Education and Hospitals, Grievance, Disaster Medical Care, Laboratory Evaluation, Occupational Health, Public Safety, and Prepayment Plans and Organizations.

The Committee to Study Committees expects as time goes by that need for changes in the size, function and duties of committees will occur. We shall continue to carefully observe how well the present committee structure fulfills the purpose of the Society.

H. Close Hesseltine, *Chairman*
Harlan English
Arthur F. Goodyear
E. A. Piszczek
Ceasar Portes
Jacob E. Reisch

REPORT OF THE LIAISON COMMITTEE TO THE ILLINOIS PHARMACEUTICAL ASSOCIATION

Our committee meetings in 1963-64 included four meetings with representatives of the Illinois Pharmaceutical Association. One of our committee and the chairman of the Board of Trustees, Dr. DuPuy, and the chairman of the Drug Formulary Committee, Dr. Weatherly attended a two day conference on Medicine and Pharmacy at the national level. The salutations to that Congress were from the Commission on Medicine and Pharmacy, whose participating members are the American Medical Association, American Pharmaceutical Association and the National Association of Retail Druggists. Problems facing medicine and pharmacy, ethics and law, a joint responsibility, the economics of Medical Care, and interprofessionalism were among the subjects discussed there. Our state level conferences have been on similar subjects.

Copies of a proposed Code of Interprofessional Relations of Physicians and Pharmacists in Illinois, as developed by our two state liaison committees, were distributed to the ISMS Board of Trustees. Consideration will be given the Code by the 1964 House of Delegates following Board approval.

Your committee seeks counsel on topics pertinent to our liaison duties with the Illinois Pharmaceutical Association which agrees that conference table plans are preferable to legislative hall decisions.

The chairman thanks our committee members, and also Mr. Richards, who has attended every meeting.

George B. Callahan, *Chairman*

COMMITTEE ON QUACKERY

Report not available at publication time. Please check handbook index for late reports.

MEMBERSHIP COMMITTEE

At the May, 1963, meeting of our House of Delegates, the constitutional requirement of United States citizenship for membership in the ISMS was amended to provide a provisional membership for those who have indicated their intention of becoming United States citizens. Provisional membership terminates one year after the expiration of the minimum period of time within which such a member could have perfected his citizenship.

Introduction of this new category of membership at the county level should provide our Society with many new, fully-qualified but foreign-born, members who have been excluded in the recent past because of the statutory citizenship requirements. It is hoped that the county medical societies will make appropriate changes in their Constitutions and Bylaws. These eligible physicians could then become active participants in our Society's program and progress. They will also serve to protect us from any possible loss of a delegate to the American Medical Association through attrition of members. An additional 500 members would increase the available budget of the State Medical Society by $30,000, exclusive of the AMA-ERF contribution (this would have great significance in our public affairs activities and in the defense of our freedoms).

Our committee has continued to support the efforts of the county medical societies in acquiring new members from the ranks of physicians now in academic, administrative, and comparable areas (a moderate number of these physicians are not members). The participation of these individuals in the activities of our county, state and national medical organizations would be mutually advantageous. Because of Chicago's position as a leading center of medical education and research, there are an above-average number of physicians in resident-training programs in Illinois, and efforts will be made by the Chicago Medical Society in 1964-65 to expand our membership from these sources.

In relation to the total physician population, the percentage of physicians "not-in-private" practice has increased markedly during the past 30 years. Excluding interns and residents, approximately 39,000 physicians in the U.S. were not in private practice in 1960. The causes for this increase are many, but a few major contributing factors are: (1) increased number of physicians in hospital service; (2) increased number of full-time faculty personnel; (3) employment of physicians by consumer and labor-sponsored plans; (4) employment of physicians by industry and other allied occupational health programs. Thus the not-in-private practice group is large, it is growing, and it is becoming an increasingly influential segment of the physician population.

Active and dues-paying members of the American Medical Association as of May of 1959 could be divided into the following categories:

83 per cent of all full-time specialists were active dues-paying members, 78 per cent of all part-time specialists were active dues-paying members, 64 per cent of all general practitioners were active dues-paying members, and 35 per cent of all physicians not-in-private practice were active dues-paying members. It is evident that the percentage of physicians in private practice who are active AMA members is considerably higher than the percentages for those not-in-private practice.

In an effort to remedy this low active dues-paying membership record of physicians not-in-practice and to strengthen the AMA as an organization for *all* doctors of medicine, the House of Delegates of the AMA has recommended that state and county medical societies:

A. Make every effort to bring physicians not-in-private practice into full active voting membership by:
   1. Permitting membership consideration for physicians having a license to practice in any state;

2. Waving requirements that a state license be obtained where physicians' activities do not require licensure;
3. Repeal or amend any provisions that impose unduly prolonged residence requirements.

B. Grant a dues-reduced or dues-exempt membership to residents and interns.

C. Re-evaluate programming so as to make medical society meetings of interest to physicians not-in-private practice, as well as to those in private practice.

The Board of Trustees of the AMA has gone on to say that it is evident that difficulties and problems will be encountered at various organizational levels in the implementation of any or all of the above recommendations. However, the realization by the various state and county medical societies of the importance of making membership available to physicians not-in-private practice will be a big step toward greater unity within our profession.

In the opinion of this committee, the Illinois State Medical Society has already assumed a leading position in implementation of the first two remedies mentioned above. It is our recommendation that the House of Delegates of the Illinois State Medical Society go on record in favor of strong efforts on the part of each of our component medical societies towards development of substantial membership programming directed towards eligible and qualified physicians that are not-in-private practice, as well as those that are. Program material along these lines may be developed and additional assistance can be provided by the staff of the Ilinois State Medical Society, if it is requested by the county medical societies.

H. Close Hesseltine, *Chairman*
W. C. Bornemeier
Casper Epsteen
Harold E. Himwich
Joseph O,Malley
H. D. Scott, Jr.

COMMITTEE ON CONSTITUTION AND BYLAWS

The Committee on Constitution and Bylaws received from various sources, suggestions for modification of the Bylaws in twelve areas. Each suggestion has been considered, and the committee recommends the following actions to the House of Delegates.

ITEM I

In the action taken by the House of Delegates at its 1963 meeting, the requirement of citizenship as a prerequisite for membership in the Illinois State Medical Society was deleted from the chapter on "membership" except where it pertained to resident and intern members.

The Committee on Constitution and Bylaws has been assured by the Reference Committee on Changes in the Constitution and Bylaws that this was an oversight, and that it was the intention of the reference committee to remove the requirement in the case of residents and interns also.

To accomplish the intention of the Reference Committee, we propose

AMENDMENT TO:

CHAPTER I, Section 5 to delete: "who is a citizen of the United States,"

and

CHAPTER I, Section 6 to delete: "and must be a citizen of the United States."

(Through error, these corrections were edited into the current copy of the Bylaws in your possession so that the phrases we propose that you delete do not appear there. The House of Delegates *did not vote* their removal, however, and these amendments proposed *official* action to remove the phrases)

It was discovered that although this same requirement—citizenship—was deleted from CHAPTER I, Section 2, it was overlooked in CHAPTER XI, Section 4, and remains there as a prerequisite for component society membership. To correct this inconsistency, we propose the

AMENDMENT OF

CHAPTER XI, Section 4 to delete the words "and a citizen of the United States."

ITEM II

In that portion of the report of the Reference Committee on Changes in the Constitution and Bylaws pertaining to the Committee on Prepayment Plans and Organizations, 15 lines of printed matter specifying the procedures, reports and recommendations of that committee, were omitted. To return them to the Bylaws we propose the

AMENDMENT OF

CHAPTER IX, Section 13, by adding:

"After being notified of the decision of the committee, a member of the Society shall have 30 days to appeal for a rehearing before the committee. If after careful investigation, the Committee on Prepayment Plans and Organizations finds that the complaint cannot be adjudicated amicably, the committee shall report the matter to the county society. If factors in the case warrant it, the committee may recommend that charges of unethical conduct be preferred against the offending member, or that agreements with plans and organizations be re-evaluated.

"Failure to appear on order of the committee may be grounds for citation of unprofessional conduct to the county society."

ITEM III

A controversy has arisen between adjacent counties over the membership of physicians who reside in one county, but practice in more than one county.

The Bylaws concerning component societies say in CHAPTER XI, Section 4, "Every physician

. . . . . who resides in the jurisdiction of *a county society* . . . . . shall be eligible for membership". . . . . and later in Section 7: "A physician living on or near a county line may have his *membership* in *the county* most convenient for him, upon permission of the component society in whose jurisdiction he resides."

To resolve this problem, the Bylaws might be clarified by

AMENDING

CHAPTER XI, Section 4 by addition of the underlined phrases, so that it would read:

"Every registered physician holding the title of Doctor of Medicine or its equivalent, who resides in the jurisdiction of a component society, and who is of good moral character and professional standing, shall be eligible to membership *in that component society.*

"A physician living on or near a county line, *or practicing partly or totally in an adjacent county,* may hold his membership in the county most convenient for him, *provided he submits written authorization to that society* from the component society in whose jurisdiction he resides."

ITEM IV

Because of the need for order and coherence in the Constitution and Bylaws, and because the Reference Committee on Changes in the Constitution and Bylaws may not have opportunity to research the documents adequately, it has been suggested that a member of the Constitution and Bylaws Committee assist the Reference Committee in the preparation of the reference committee report to the House of Delegates. To accomplish this, we propose

AMENDING

CHAPTER X, Section 8, by adding the italicized sentence so that it would read:

Section 8. The Reference Committee on Changes in the Constitution and Bylaws. This committee shall consider all proposed amendments to the Constitution and Bylaws. *The chairman of the Constitution and Bylaws Committee, or his representative, shall serve in an advisory capacity to this referenee committee and shall attend all sessions, ineluding the executive sessions of the Referenee Committee, to assist in the preparation of the report of the eommittee to the House of Delegates.*

ITEM V

The House of Delegates referred to this committee the recommendations of the Second Vice President (Joseph R. Mallory) in his report to the House in 1963, that the Bylaws be amended to give the Vice Presidents the right to vote in the meetings of the Board of Trustees.

The Committee on Constitution and Bylaws does not endorse this item, and recommends to the House of Delegates that it "do not pass."

ITEM VI

The Bylaws of the ISMS call for a meeting of the House of Delegates during the annual convention, and custom has provided that this meeting be held in several "sessions."

Minutes of a meeting are continuous and current, and although not edited during the meeting, are available for reference at all times.

The Bylaws provide that the speaker preside over the sessions of the House of Delegates. For these reasons, the committee proposes

AMENDMENTS TO

The ORDER OF BUSINESS as printed on page 14 of the 1963 edition of the Constitution and Bylaws to

DELETE the words "First Meeting" and "Last Meeting," and to

SUBSTITUTE the words "First Session" and "Last Session" and to

STRIKE under "Last Meeting"

"4. Reading of minutes of last meeting", and renumbering the subsequent sections, and by

STRIKING from the last item, the words "by the new president".

ITEM VII

The Impartial Medical Testimony Committee pointed out to the Committee on Constitution and Bylaws that its functions, to be most efficient, and open to the least criticism, should be conducted through physicians who have no other contact with members of the legal profession.

We have recognized the validity of this argument, and propose the

AMENDMENT of

CHAPTER IX, by deleting Section 11, and by SUBSTITUTING new Sections 11 and 12, to read;

"Section 11. Medical Legal Committee. The Medical Legal Committee shall consist of five members appointed by the Board of Trustees.

It shall

(1) educate the members of the medical profession in medico-legal affairs, and

(2) co-operate with the American Medical Association in its program in the same fields.

It shall evaluate medical testimony given by physicians in the courts of Illinois. When questions on the validity of testimony arise, it shall have the authority

(1) to examine any member of the Illinois State Medical Society who is either suspected of or has been accused of giving improper testimony in any court proceedings

(2) to procure and examine transcripts of court testimony to determine whether or not fraudulent testimony has been given, and

(3) to report its findings to the Board of Trustees."

Where irregularities are found, the Board of Trustees may submit the findings to the Ethical Relations Committee of the county medical society

for action.

It shall appoint a sub-committee to act in liaison with members of a similar committee of the Illinois Bar Association in matters involving both professions.

"Section 12. Impartial Medical Testimony Committee. The Impartial Medical Testimony Committee shall consist of nine members appointed by the Board of Trustees.

It shall cooperate with the judiciary in both federal and state courts within the State of Illinois.

It shall, when requested by the court, implement the Impartial Medical Testimony Rule."

Then: Sections 12 to 22 are to be renumbered to become respectively Sections 13 to 23.

In Section 1—add after "A Medical Legal Committee"—"A Committee on Impartial Medical Testimony" . . .

ITEM VIII

The Committee received a suggestion that resolutions submitted too late for publication in the April issue of the Illinois Medical Journal be penalized by requiring a greater than majority vote for passage.

We believe that the House might consider

AMENDING

CHAPTER XIII Miscellaneous by adding:

"Section 3. Resolutions. Resolutions to be considered by the House of Delegates, shall be submitted in writing prior to March 1 for publication in the April Issue of the Illinois Medical Journal. Resolutions received too late to be published, must be submitted in proper form and in sufficient number to afford one copy for each member of the House.

Resolutions submitted after publication of the April Issue of the Illinois Medical Journal shall require for passage an affirmative vote of two thirds of the members present."

ITEM IX

A recommendation was received that the House of Delegates should be required to ratify committee appointments made by the Board of Trustees. It is the opinion of this committee that this recommendation should be rejected because:

(1) the Board of Trustees is not constituted until the final session of the House of Delegates

(2) the chairman of the Board of Trustees is not elected until after the House has adjourned, and

(3) the committee members are not appointed until one or more months have elapsed after the House has adjourned, and

(4) the Bylaws provide that the Board of Trustees committees shall be approved by the Board.

ITEM X

The Committee on Constitution and Bylaws was asked to consider a provision to require District Laboratory Evaluation Committees. The suggestion was not received favorably because we were informed that there are districts where the number of pathologists available is quite limited. We agree that such committees are desirable, and propose an

AMENDMENT TO

CHAPTER VII, to add after "Prepayment Plans and Organizations," the words:

"and such other district committees as required to implement the business of the district."

The wording of this entire CHAPTER VII, has been critized as being unclear, so the chapter has been rewritten, and we propose to

STRIKE

the entire CHAPTER VII, and

SUBSTITUTE

the following as a new chapter:

"CHAPTER VII. District Committees. Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Grievance Committee, a Committee on Prepayment Plans and Organizations, and such other committees as required to provide to each component society, those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected, subject to the general rules on composition of committees contained in sub-paragraph II, Section 4, Chapter IX of these Bylaws, at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex officio member of each committee.

ITEM XI

We propose

AMENDING

CHAPTER VI. The Board of Trustees. Section 2. The Duties of the Board of Trustees.

to add at the end of the paragraph:

"The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates" and

CHAPTER IX, Section 8. Add a new paragraph:

"Any committee shall report to the Board of Trustees when requested by the Board to do so."

ITEM XII

The Committees to Study Committees recommended that a division be made in *CHAPTER IX. Committees:* to separate into sections the committees appointed by

(A) the Board of Trustees, and

elected by:

(B) the House of Delegates.

To accomplish this we move that

CHAPTER IX. COMMITTEES. Section 1 be deleted and a new Section 1 be substituted to read:

Section 1. Standing Committees. The Standing Committees shall be:

A. Elected by the House of Delegates:
- A Committee on Medical Education
- A Grievance Committee
- A Committee on Prepayment Plans and Organizations
- A Committee on Disaster Medical Care
- A Committee on Laboratory Evaluation
- A Committee on Occupational Health
- A Committee on Public Safety

B. Appointed by the Board of Trustees:
- A Committee on Scientific Assembly
- A Medical Legal Committee
- A Committee on Impartial Medical Testimony
- A Committee on Legislation
- A Committee on Public Relations
- A Committee on Medical Benevolence
- A Committee on Archives
- A Committee on Constitution and Bylaws

Then we propose that the subsequent sections be rearranged

Sections 10, 12(13); 13(14); 19(20); 20(21); 21(22); 22(23); 9, 11, new section on IMT (12), 14(15); 15(16); 16(17); 17(18); 18(19) to become respectively:

Sections: 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23.

Andrew J. Brislen, *Chairman*
Keith H. Frankhauser,
M. Mijanovich
John H. Steinkamp
George H. Woodruff
Ex-officio: Walter C. Bornemeier

COMMITTEE TO REDISTRICT ISMS

This Committee has, after due deliberation, considered that the job of redistricting the Medical Society is one of rather tremendous magnitude with many facets to be considered.

To aid in determining the most advisable and acceptable method for redistricting, questionnaires will be sent out to County Medical Society Officers before further work is undertaken.

It is the opinion of this Committee that the job of redistricting is not one which can be done in a hurry but will take several years before it can be properly accomplished. With this thought in mind the House of Delegates is requested the allowance of further time to this Committee to continue its work.

J. W. Compton, *Chairman*

Gordon T. Burns	Noel G. Shal
John A. Newkirk	A. Everett Joslyn, Jr.
Eugene P. Johnson	Henrietta Herbolsheimer

Summary of Questionnaire Sent to the ISMS Board of Trustees

There were 12 replies received from officers and members of the Board to the questionnaire mailed out by the committee. The same questionnaire is being sent to county medical society secretaries. Their replies will be catalogued and submitted as a supplementary report of this committee, if sufficient information is on hand prior to the May meeting of the House of Delegates.

(1) On what basis would you redistrict ISMS—and why:

No reason to change	3
Population	3
Highways—ease of travel for trustee	2
Highways—ease of travel for M.D.'s	1
To serve physicians better	1
Use medical service areas	2

(2) Are there any immediate areas in which you would like to be affiliated?

No	5
Not to be considered	1
Change only if trustee areas are too big	1

(3) Are there any areas in your vicinity with which you would NOT like to affiliate?

No	5
Not to be considered	1
Only if area is too big	1

(4) Do you think the number of Trustee Districts should be increased, even though this might mean an increase in expenses and dues?

No	10
Board is large now	3
Chicago should have more	3
Stay the same—increase only if necessary	1

(5) Do you feel your District should be larger or smaller?

No change	5

(6) Outline suggestions to develop better rapport and better communications between trustee and his district:

Combine meetings of small societies and schedule at least four a year	1
Develop better informative communications by trustee with county society officers	3
Have Chicago trustees responsible to specific branch societies	2
Keep county society officers (especially secretaries) for several years	1
Use district meetings of county society	

delegates with the trustee	1
Develop more field visits by staff	1
(7) Suggestions:	
Chicago should have more trustees	2
Downstate should have fewer	2
Executive committee of the Board should handle more of the business and have fewer Board meetings	1
Don't send this questionnaire to the county society secretaries—send it to the delegates	1
Don't change the present setup	2
Don't change Chicago	1

When the material comes in from the 92 county society secretaries (who have been asked to discuss these problems with the other officers and with the delegates) the material will be prepared for a supplementary report to the House which will be found in the packet distributed at the opening meeting on Sunday evening, May 17.

PRESIDENT, WOMAN'S AUXILIARY

The "SAC" program (Serve and Communicate) of the National Auxiliary coupled with the state theme, "The Art of Giving" has elicited a great deal of enthusiasm and activity throughout Illinois. Members were eager and willing to promote the Auxiliary program and gave of their time, energy and talents to assist the Illinois State Medical Society in whatever activity they were called upon to perform.

This activity was made more pleasurable due to the wonderful cooperation and support given to the Auxiliary in all of its endeavors by the Illinois State Medical Society and its Staff. Since the success of the State Society and Auxiliary program is dependent on "grass root" participation, there should also be a demonstration on the part of the County Medical Societies as to the need which the Auxiliary can fill and cooperation on the part of both to achieve these goals. This is important for the progress and growth of our organization.

Many things have been accomplished during the year due to this corollary between the Illinois State Medical Society and its Staff and the Woman's Auxiliary. It is gratfying to highlight a few.

(1) Administrative services rendered to the Auxiliary.
(2) Cooperation and attendance at District meetings.
(3) Attendance of Officers and staff at Board meetings.
(4) Appointment of liaison Auxiliary representatives to various committees of the Illinois State Medical Society.
(5) Preparing a realistic budget with our Finance Committee, enabling the Auxiliary to function within the scope of its resources.
(6) Membership in the United States and Illinois Chamber of Commerce.
(7) "Retirement" of Auxiliary pin on a bronze plaque recognizing the service of all Past State Presidents to date.

A summary of the president's activities for the year includes the following:

(1) Compiled material for the state roster.
(2) Credential cards and letters of instruction to all delegates and alternates to the National convention in Atlantic City, were sent out with the aid of the corresponding secretary.
(3) Attended the National convention and served as chairman of the Illinois delegation.
(4) Sent out pertinent information which included general instructions for the State Officers, Councilors, Commttee Chairman and County Presidents. Included in this was a suggested agenda for District meetings.
(5) Presided at the Post-Convention, Fall and Spring Board meetings.
(6) Attended the national fall conference for state presidents and presidents-elect in Chicago.
(7) Attended the 16th National Rural Health Conference in Hot Springs; the A.M.A. Institute; National Safety Council meeting; AMPAC meeting emphasizing Public Relations; Cook County Membership Evaluation committee meetings; Legislative Conference in Springfield and introduction on the floor of the Senate; Convention of the Illinois League for Nursing, Inc., Congress on Mental Health; Public Affairs Conference in Washington and meeting of the U. S. Chamber of Commerce, visiting with Illinois Congressmen; served ex-officio on the Medical Services and Scientific Assembly committees on the ISMS; attended Committee Workshop Meeting of the Illinois State Medical Society at which Auxiliary officers participated and served as official representatives of that group. Liaison representatives to the various committees of the ISMS include: Aging, Cancer Control, Disaster Medical Care, Mental Health, Public Safety, Legislation, Religion and Medicine, Medical Services, Scientific Assembly and Public Affairs.
(8) Presided at the Executive Board Meeting with the Advisory Committee of the ISMS to study recommendations and to evaluate the program of the year.
(9) Visited the State Conventions of Michigan, Indiana and Wisconsin.
(10) Attended and participated in the 11 District meetings throughout the state. The meetings were well planned by the Councilors involved in conjunction with the County Presidents within that district. Basic materials were presented in order to operate efficiently, program and reference material was made available; membership was stressed with maps of Illinois showing areas in need of organization; emphasis was placed on "The Art of Giving" in community service activities; all the dis-

trict meetings were covered by Mr. Widmer who spoke on current legislation or by Mr. Richards. Luncheon speakers and programs were excellent. These Workshop Conferences serve a definite need in the Auxiliary as they serve to bring the entire program into the Counties and to the individual members who actually do the work.

(11) Spoke at twenty county meetings and attended programs and functions of these Auxiliaries. Also participated in several Branch meetings. The subject of the talk in the county was "The Role of the Doctor's Wife in the Community". This presentation was highlighted with experiences and activities of other Auxiliary members who were performing outstanding services in their respective communities throughout the State. The members were pleased to hear of these activities and were in accord with our ideals and inspired and proud to be members of this organization. Many county Auxiliaries do work "hand in hand" with their Medical Societies and have made a real contribution in many successful undertakings.

(12) Worked closely with the president-elect and other members of the Board and attended all committee meetings when necessary. In preparing for the Convention the president is in contact with the ISMS Officers, the Staff and the Convention Chairman.

(13) The following material has been written and sent: Letters of information and materials to the Board members, County presidents and Members-at-Large; required information to the Woman's Auxiliary to the A.M.A., ISMS Officers and Staff; president's messages for the Pulse; an article for the March issue of the Bulletin of the Wowman's Auxiliary to the AMA; an annual report of the Auxiliary activities for the ISMS Journal and Delegate Handbook; a report on Illinois' activities for the national historian; copy for inclusion in the membership packet of the ISMS and answering all correspondence and requests pertinent to this office.

(14) Established a Loan Closet Service in a local area for Cancer patients.

It is a pleasure to report on the outstanding work accomplished by the officers, directors, councilors and committee chairmen. They have made the Auxiliary activities a very worth while endeavor. Not only have they performed their own tasks with efficiency and enthusiasm, but they have joined with the State Society in promoting the Medical Self-Help program on TV, and have received awards of recognition for their individual participation. Rural Health activities have been felt as far away as Arkansas. At several of the National meetings the presence of women was noted and commented upon for the first time. There are many other interesting things to report but space does not permit. It is evident that the "heart of the home" is active, but she also likes the "head" to tell her she is needed.

We wish to express our warmest appreciation to the Advisory Committee of the Illinois State Medical Society for their friendly advise and wholehearted cooperation. Dr. Edward A. Piszczek, Chairman; Dr. Harlan English, President; and Dr. Newton DuPuy, Chairman of the Board of Trustees are to be commended for their interest and service to the Auxiliary.

It was an honor and a privilege to serve under Dr. Harlan English, President of the Illinois State Medical Society during this year.

It is difficult to enumerate all the services and expert advice which emantes from the office of the Illinois State Medical Society with Mr. Robert L. Richards, executive administrator and his capable and courteous Staff available whenever called upon. We, in Illinois, are very grateful that the State Society offers this wonderful service to the Auxiliary, and wish to thank each and every one who helped us in all of our undertakings.

The Woman's Auxiliary to the Illinois State Medical Society with its various activities and priority projects will continue to bring medicine's story into the community by serving and communicating, and feels privileged to be able to assist the Illinois State Medical Society in "The Art of Giving", through our membership in the Auxiliary.

Mrs. Matthew E. Uznanski

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

The Committee held one formal meeting with the Executive Board of the Woman's Auxiliary on October 6, 1963. The Committee has also been consulted on several occasions for guidance in policy matters by the President of the Auxiliary. The Auxiliary President has also consulted the Executive Administrator about the administration of her program, and about the correlation of her committee activities with those of the State Society.

Mr. Uznanski, President of the Auxiliary, has described the details of the Auxiliary program in her report. We urge the House of Delegates to read it carefully.

Specific mention should be made of several innovations which have been agreed upon, and which will be continued in the future. We have suggested to the proper individuals that the liaison representatives of the Woman's Auxiliary be continued on certain committees of the State Society. In addition, we have also suggested that such liaison representatives from the Auxiliary be added to other important committees. The Board of Trustees has accepted this as standard operating procedure for the future.

The Committee has provided increased administrative services from the headquarters office. These services include the preparation of reports, secretarial services, and administrative advice to the Auxiliary officers and committee chairmen. A complete listing of the services performed for the Auxiliary is available from the Executive Administrator. These services have been known to the officers of the Auxiliary.

We have encouraged the Auxiliary to become active in the Illinois State Chamber of Commerce and in the Chamber of Commerce of the United States. These organizations advance the purpose of free enterprise, and they provide resource materials upon which the Auxiliary might base its community service programs.

State and county medical society officers and staff members who have attended Auxiliary District Meetings have assisted the Auxiliary in developing a much better understanding of the desired cooperation of the Auxiliary committees and ISMS projects and programs. Assistance is also provided to the Auxiliary in planning and conducting its convention.

In summary, we maintain that the Auxiliary has provided a wealth of inspiration and financial assistance during the past year. We particularly commend Auxiliary officers and its Board of Directors for excellent cooperation and helpfulness. We look forward to a continuation of fine relationships and activities.

E. A. Piszczek, *Chairman*
Harlan English
Newton DuPuy
Ex-officio: Robert L. Richards



COMMITTEES ASSIGNED TO ECONOMIC AND LEGISLATIVE ACTIVITIES

COMMITTEE ON ARCHIVES

The archives of the medical profession in Illinois reflect the origins, characteristics, personalities and the developments of medicine in the State. For these reasons, the Committee stresses the collection and preservation of such historical material. The Committee also urges each county society to collect and preserve items of local significance, and it encourages individual physicians to note and retain records and documents of the profession which have historical value. Local archives play an important role in stimulating professional and lay interest in medical history.

The Committee shall continue to pursue those activities which will ensure the collection and preservation of medical material that has a special historial significance to the Society and to the public.

Paul P. Youngberg, *Chairman*
James H. Hutton
Josiah J. Moore

COMMITTEE ON MEDICAL MUSEUM

The subcommittee on the Museum of Medical History has explored a course of action for a medical museum. The report of this committee follows.

The Medical Museum Committee met in Chicago on December 12, 1963. Several experts and professionals, representing other medical and health museums, attended.

The committee heard Mr. Clyde Walton, State Historian, offer northeast quarter of the old State Capitol Building (formerly office of Secretary of State) to the committee for use as a medical historical museum. Mr. Walton commented that it was appropriate to have the Medical Society use this area in a historic building to commemorate the contributions made by the medical profession, and to recognize the fact that the organization meeting of ISMS was held in this building. He stated that the Illinois Bar Association will occupy similar space across the hall and will feature a "Lincoln The Lawyer" theme in its exhibit. Perhaps ISMS could develop a historic exhibit based on a "Lincoln Family Doctors" theme.

The committee voted unanimously to recommend that the Council and The House of Delegates proceed with plans for establishing a museum. The committee also approved the employment of a professional person to formulate plans for the museum. Such a person might be a postgraduate history student. The usual stipend for this kind of assign-

ment is about $2000 per annum.

A brochure, setting forth proposals regarding the museum, has been prepared for distribution to members attending the meeting.

ISMS would be expected to raise $85,000 for its prorated share in restoring the old Capitol Building. After the museum has been established, there will be no continuing expense for guide service, utilities, upkeep, etc.

Emmet F. Pearson, *Chairman*
James H. Hutton
E. P. Coleman
Tom Kirkwood
Leo Zimmerman
Clifford E. Smith
Carl W. Hagler
John A. Newkirk

COMMITTEE ON LIAISON TO ILLINOIS BAR ASSN.

The Committee reports that liaison continues with the counterpart committee of the Illinois Bar Association in an effort to resolve medical-legal problems of mutual concern.

The subject of prime consideration is that of the present Discovery Deposition procedure. The abuses and excesses which prevail were thoroughly reviewed by the joint committees. The Discovery Deposition Resolution (63-16), as originated by the Chicago Neurosurgical Society, was presented to the Bar Committee. This Resolution recommends corrective action to reduce or eliminate the existing objectionable conditions. The Bar Association Committee is studying the suggested changes and will meet in separate sessions to prepare recommendations on the subject to the Board of Governors of the IBA. Follow-up actions with the Illinois Judical Conference and the Illinois Supreme Court, are contingent on the actions of the Bar Association.

Two additional medical-legal subjects are also being considered by the joint committees. These are: the Impartial Medical Testimony Program, and Medical Malpractice cases.

Material on IMT in action was presented to the Chairman of the Bar Association Committee. This Committee is reviewing the subject and is planning a statement of recommended action.

For further discussion of the subject of medical malpractice, the Committee has obtained copies of medical screening plans as implemented in other states. These plans will be studied and discussed in subsequent meetings.

The Committee realizes the great value to both professions of liaison interaction in medical-legal affairs. We shall continue a program of effective liaison to facilitate the disposition of medical-legal problems.

Luis V. Amador, *Chairman*
Samuel A. Levinson
Leo P. A. Sweeney
George C. Turner
Darrell H. Trumpe
Ex-officio (Staff): John W. Neal
Paul Swarts

COMMITTEE ON MEDICAL BENEVOLENCE

During the year, the caseload on the Benevolence Program has fluctuated between 35 and 40 beneficaries. These beneficiaries received a total of $31,970.45 during the fiscal year ending December 31, 1963. This expenditure was offset by investment income of $5,509.81; gifts, totalling $6,771.40, from the Auxiliary and others; and a $2.00 allocation from dues, amounting to $18,527.00. This represents a total income of $30,808.21. A deficit of $1,162.24 is to be made up from regular society operating funds. Deficits in previous years have varied between $5,000 and $8,000. The favorable position in 1963 is due to a better investment income, and also to the fine work of the Auxiliary.

In November, 1963, the Committee met to review the financial situation and to consider its operating policies. Suggestions for altering the plan of financing to eliminate the annual deficit charged aganst the general operating funds were presented to the Board in January. Revisions to the Committee's general operating policies were also considered and presented to the Board of Trustees in January. These include a minor revision in the procedure for reviewing accepted cases on a periodic basis. The following additional policy has been added:

"A spouse who s legally divorced from the physician-member is not eligible for Benevolence Assistance."

The Committee wishes to express its sincere appreciation to the Members of the Woman's Auxiliary for their support and contributions to the Benevolence Fund. Guidance from the Finance Committee, and the Board of Trustees has been helpful in our work.

Keith H. Frankhauser, *Chairman*
John H. Steinkamp'
Raleigh C. Oldfield

LIAISON COMMITTEE TO DEPARTMENT OF REGISTRATION AND EDUCATION

The Committee calls attention to its meeting with the Director of the Department of Registration and Education and members of his staff on February 11, 1964. This meeting was concerned with enforcement of the various licensing acts. Representatives from the Chicago Medical Society, the Cook County Physicians Association, the Illinois Chiropractic Association, the Illinois Osteopathic Association and the American Medical Association, were also present at this meeting.

The Director outlined a five-point program designed to uncover all those individuals who practice the healing arts without licensure, and to initiate the appropriate legal pressure which would clear the state of unlicensed practitioners. This program is to be implemented on or about March 1, 1964. The five points which the Director made are:

(1) Some hospitals apparently have physicians who are practicing without licenses. A survey of all hospitals will be made in order to

secure the name and license number of each physician on their staffs. Nursing homes and private clinics will be included in this survey.

(2) General inspections, in which visitations to the individual doctor's office to assure the Department that the license of the practitioner is in order, will be made. Chiropractors are especially being checked in this regard.

(3) Under Section 9(a) of the Medical Practice Act, chiropractors are obliged to continue their studies in preparation for examinations. Should it be discovered that they are not continuing their educational programs, permission to continue in practice will be removed.

(4) Approximately 100 violators of the Chiropractic Act have been uncovered. Forty such cases have been filed with the Legal Department of the State. These will continue to be pursued.

(5) It has been discovered that most of the chiropractors who are practicing without a license have taken the examination and have failed to pass. These chiropractors will be carefully watched.

Realizing that licensing is a subject of great importance, the Committee holds itself ready to offer its advisory services as they are desired by the Director of the Department of Registration and Education. The Director was requested to present his five-point program to the State Society in writing so that the county societies and officers could be properly advised. At the time of this report it is planned to publish such information—when it is received—in the *Illinois Medical Journal*, and also to notify the county societies.

Jacob E. Reisch, *Chairman*
E. A. Piszczek
H. Close Hesseltine

COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony Program continues as a vital part of judicial administration in the disposition of personal injury cases in Illinois.

The legal basis for the introduction of impartial medical experts is Supreme Court Rule 17-2. It is worthy of note that the IMT Committee of the Illinois judicial courts suggests that the IMT concept "be retained as a rule of court." It is evident that the statistics of personal injury cases in which Rule 17-2 calls for examination by impartial medical experts have not been impressive. The Committee wishes to stress the point that the raw figures of IMT cases do not adequately reflect the degree of success of the program. The feature to be highlighted is the fact that the rule, an available procedure of the court, has had a salutary effect in that (1) it inspires realistic medical reports of injuries and effects, and (2) it enhances early settlement of the cases.

When, in the discretion of the judge, Rule 17-2 is invoked to introduce an impartial medical examiner, it unquestionably (1) encourages a pretrial settlement, or (2) promotes jury determination of a just verdict.

The total IMT program effect is to facilitate the equitable distribution of personal injury cases.

Efforts of the Committee have been directed toward generating greater acceptance of IMT through educational and informational activities.

One such activity was represented by a letter in which IMT programs for meeting of county and branch societies were offered. The demand for such programs necessitated the creation of a Speakers Roster. This has been accomplished. Several IMT presentations will be made in ensuing months.

The special medical-legal feature of the State Annual Meeting wil be an IMT luncheon on Monday, May 18, 1964. Justice "X" will be the principal speaker. His address will cover the subject *Medicine and Law*. Particular emphasis will be placed on impartial medical testimony. Judges, lawyers, and other interested persons will be invited to attend.

An internal IMT action designed to strengthen interest in the program is the quarterly *Newsletter*, which is prepared for the IMT panelists.

The Committee continues to pursue productive liaison campaigns with the American Bar Association (which adopted a resolution endorsing IMT), The Illinois Bar Association, the judiciary and legal professions, and lay groups.

Research of IMT cases in Illinois is underway to provide case characteristics and enlightening information that will be of interest to doctors, judges, and lawyers. A survey of judges in Illinois wil be undertaken by the Court Administrator's office, as directed by Judge Charles Barrett. Judge Barrett is the Chairman of the IMT Committee of the Judicial Council. The purposes of this Committee is to determine essentially why the judges have not invoked Rule 17-2.

The Committe believes that these and like efforts will encourage greater use of IMT in the courts, as requested by attorneys (plaintiff and defendant) and as ordered by the judges.

Continued financial support of the program is assured. The Ford Foundation recently extended its initial grant of $25,000 to July 1, 1965. Other contributors include the Woods, Wieboldt, and Deere Foundations. These sustaining contributions certainly express an awareness of IMT's value, and of confidence in the ultimate growth of the program. The Committee supports this confidence and feels that continued efforts toward education, information, and liaison will justify the program.

The Illinois State Medical Society has appointed Mr. Paul S. Swarts as staff representative to render administrative services to the Committee on Impartial Medical Testimony.

The Committee expresses its sincere thanks to

the physicians who have participated in the program, those who are available for IMT service, and all others who by word of mouth and action have contributed to the development of IMT.

Samuel A. Levinson, *Chairman*

Clinton L. Compere	Percy E. Hopkins
John B. Condon	Roland P. Mackay
R. Gregory Green	Harold C. Voris
Roger A. Harvey	Warren W. Young

Consultant: Edmund F. Foley
Ex-Officio: Frank J. Jirka, Jr.

COMMITTEE ON LABORATORY EVALUATION

The Committee on Laboratory Evaluation submits no requests for action by the House of Delegates at this time.

Proposed future activities of this Committee will be related to the implementation of its Program and to the provision of requested assistance to local Committees on Laboratory Evaluation.

A chronologic review of activities of this Committee for the past year is as follows:

(1) The Program of this Committee was presented in an article entitled, *The Physician and the Clinical Laboratory—A review of the current status in Illinois,* published in the Illinois Medical Journal, July, 1963.

(2) On December 4, 1963, the Presidents of the County Medical Societies and branches of the Chicago Medical Society were provided with a memorandum outlining their option for the formation of local Committees on Laboratory Evaluation. Copy of this letter is attached as Annex 1. Subsequent to passage of the Illinois Clinical Laboratory Registration Act, it becomes apparent that a strict interpretation of the wording of this Act would exclude certain Laboratories directed by Physicians from registration. This would exclude from some of the best staffed and most effective clinical laboratories in the State from the Laboratory Registration. The Board of Trustees of ISMS has subsequently recommended to all members of this Society that they take the opportunity of registering their laboratory facilities—even though such registration is not specifically required. Copies of necessary registration forms are available to physicians on request. Such requests should be directed to the Chairman, Committee on Laboratory Evaluation, Illinois State Medical Society, 360 North Michigan Avenue, Chicago, Illinois, 60601.

(3) The Chairman of this Committee has collaborated with members of the Illinois Society of Pathologists in the preparation of a panel, *Symposium on Proper Performance of Clinical Laboratory Procedures in the Physician's Office.* This panel is to be presented at the meeting of the Section on Pathology, of ISMS on May 20, 1964. The program will include a session describing the functions of this Committee, and of the Commission on Clinical Laboratories, Blood Banks, and Blood Bank Depositories which was created by the Seventy-third General Assembly to survey and study clinical laboratories, blood banks, and blood bank depositories in this State.

(4) Members of this Committee have developed a Policy Statement for submittal to the Board of Trustees and the House of Delegates.

James B. Hartney, *Chairman*
John Maloney
Grant C. Johnson
Theodore Z. Polley
Jack Williams
Thomas P. DeGraffenried

COMMITTEE ON LEGISLATION

Amendments to the Constitution and Bylaws adopted by the 1963 House of Delegates changed the name of this Committee from the Committee on Medical Service to the Committee on Legislation. The name more appropriately describes the field of the committee's activity. It also lessens confusion on the part of our membership and others with whom we deal.

The Committee has continued its practice of meeting on the day preceding meetings of the Board of Trustees to facilitate current reporting to that body. Two formal meetings and several subcommittee meetings were held during the last Annual Meeting with all happenings in the 73rd General Assembly to that time reported to the House of Delegates in supplementary reports. The Committee held two telephone conferences on June 14 and 21, with final adjournment of the 73rd General Assembly coming on Saturday, June 29. Subsequent meetings were held in July, October, and January and March.

The final tabulation for the 73rd General Assembly shows 1238 bills introduced in the Senate and 1678 in the House, for a total of 2916. The grand total including 386 resolutions was 3302. Of the senate bills introduced, 761 were passed with 115 vetoed by the Governor. In the House, 855 bills were passed, with the Governor vetoing 117. The magnitude of these changes in the statutes, affecting the daily lives of physicians and other citizens of Illinois, cannot be underestimated. During the session, your Legislative Committee monitored about 190 of these bills, each having some significance to the practice of medicine. The progress of these bills was reported weekly to some 4000 members who were interested enough to request retention of their names on the mailing list for

On the Legislative Scene, a special newsletter published while the Assembly is in session. Capsuled highlights appeared in the monthly Journal page, called the *Legislative Listening Post*.

Unlicensed Chiropractors Permitted to Practice

The Amount of opposition to bad legislation and support of good legislation, which can be brought to bear is in direct proportion to the interest shown in these measures by members of the Society. Some of the bills that were passed undoubtedly did little to advance the cause of good medical care. Had the membership been more interested, their passage could have been prevented, and the health of the public would be none the worse. Fortunately, only one bill to which we offered vigorous opposition survived the legislative process and the Governor's veto. This was Senate Bill 1234, which permits a group of some 250 unlicensed chiropractors to continue to practice for two more years.

The special group of chiropractors who are premitted to practice were brought in under the "grandfather" clause when the Palmer School of Chiropractors was approved by Illinois for chiropractic training a number of years ago. These practitioners have been given several extensions in time to take additional training and pass the examination. The deadline for this special dispensation was January 31, 1964. Through the enactment of SB-1234, this deadline was extended for two more years. The measure was hurriedly passed through the General Assembly in the closing days of the session. We had no opportunity to be heard in the Senate and there was complete disregard for our opposition in the House. There was no lack of understanding on the part of the members of either body as to the position of the Medical Society.

The point to be emphasized here is that the members of the General Assembly were not as concerned with the opinion of physicians as they were with the opinion of the supporters of this bill. To be effective legislatively, physicians must become acquainted with their legislators. In addition to making the fact known that they will not tolerate any measures that tend to lower the standards of medical care, they must be willing to support the member when he votes correctly. All too frequently members of the General Assembly tell your Committee that they hear from physicians only when they are opposed to something. For the most part, your elected representatives will react favorably to justifiable views on these issues—if they are presented by constituents who have a voice in their election.

Operation Hometown

On the national scene, your Committee has continued active opposition to the King-Anderson Bill (H.R. 3920) through the Operation Hometown Program in county medical societies and branches of the Chicago Medical Society. Dr. J. Ernest Breed has done a fine job of organizing this program in Cook County. Likewise, Dr. Ralph Redmond has effectively organized the Downstate areas. Testimony in opposition to H.R. 3920 was presented before the House Ways and Means Committee in November by Dr. H. Close Hesseltine, a member of this Committee. He was assisted by Dr. Joseph Mallory.

Members of the Illinois Senatorial and Congressional delegations who oppose this legislation have been supported in their efforts. Numerous allies in the business world have been persuaded to join the fight against this legislation. Despite the lack of any firm support for medical care under Social Security, pressure groups continue to push for the enactment of this legislation. In a political election year, nothing can be certain on the outcome of a measure of this kind. Opposition from the medical profession must be constant.

Improved Kerr-Mills Legislation

Your Committee continues to maintain liaison with many organizations on matters of legislation. In October, a reception was held for the Board of Directors of the Illinois Chamber of Commerce to express appreciation for their assistance. We have worked closely with the State Health Department and other governmental agencies. With the passage of Amendments in the 73rd General Assembly to improve the Kerr-Mills Act in Illinois (AMIA), your Committee has worked with the Department of Public Aid and the hospitals to improve that Program. As a result of these efforts, benefits under the Program were expanded on February 1 to include up to 90 days of nursing home care and the payment for drugs during the 30-day post-hospital period allowed under the program.

Further steps have been taken with the hospitals and the Department to improve the administration of this program in order that it will more effectively serve the needy aged in Illinois. A special Kerr-Mills guide was published in the February issue of the Illinois Medical Journal. Reprints of this have been made available through hospital staffs and other avenues. In addition, a new circular describing the benefits and eligibility requirements of the program has been made available for mass distribution. In a large program such as this, administered by many different county departments of Public Aid, administrative problems will arise. The Committee again urges physicians who discover discrepancies in the administration of this program to report them to the Headquarters office in order that remedial measures may be undertaken.

Public Affairs Junket to Washington

In February, the Committee, in conjunction with the new Public Affairs Committee, sponsored a Public Affairs junket to Washington. This was the third such successful affair. Approximately 65 physicians and their wives attended for three days. The first day was devoted to breakfast and luncheon meetings to learn more about the situation in Washington from the AMA Washington staff and

a representative of the Farm Bureau. The evening was devoted to a reception and dinner for the Illinois members of the Congress. All participants had an opportunity to visit and talk personally with their own congressmen and other congressional leaders. On the last two days, participants had an opportunity to hear the major national issues discussed by top-level political figures at the Public Affairs Conference sponsored by the U.S. Chamber of Commerce. This affair not only provides an opportunity for physicians and their wives to learn how legislation is handled in Washington, but it also impresses the congressmen to know that physicians are seriously interested in what transpires in Washington.

This affair is conducted each year at about the same time. All physicians and their wives are welcome to attend. More should avail themselves of this opportunity to participate in a very stimulating legislative experience.

Liaison

Delegates should be aware that the legislative activity goes on throughout the entire year, not simply when the Congress or General Assembly are in session. Through subcommittees, we are currently working on several pieces of legislation in preparation for the 1965 session of the Illinois General Assembly. Liaison is maintained routinely with other committees of the Society on matters affecting legislation and with many official and nonofficial agencies in the health field.

Appreciation

The Committee wishes to express appreciation to the Chairman of the county Legislative Committees and others who have responded to calls for action on specific measures being voted upon. We wish to express appreciation to those physicians who have taken the time to travel to Springfield to testify before Committees. Special appreciation is due Dr. Jacob Reisch, Secretary-Treasurer, who has repeatedly helped us in securing physicians in Springfield to testify under emergency conditions. We owe a great debt of gratitude to members of the Women's Auxiliary for their help. Mrs. Matthew Uznanski, President, Mrs. Walter Shriner and Mrs. John Van Prohaska, Co-chairman of the Auxiliary Legislative Committee, have served in liaison to us and have regularly attended our meetings. Drs. Philip G. Thomsen, Frank J. Jirka, Jr., and Ralph N. Redmond, members of the Board of Trustees, serve as Ex-Offiico members of this Committee. Not only have these men served us with advice and counsel, but each has assisted us actively in numerous specific assignments throughout the year.

V. P. Siegel, M.D., *Chairman*

J. Ernest Breed
George B. Callahan
H. Close Hesseltine
C. J. Jannings

MEDICO-LEGAL COMMITTEE

The Medico-Legal Committee continues to offer its consultative services to assist physicians against whom malpractice suits have been filed. This service is, of course, available at the request of the physician involved. Although no requests for assistance have been received, the fact that the dispersion and increase in the number of malpractice suits filed against physicians is evident. For this reason the Committee strongly supports the continuation of consultative service for members of the profession.

Liason is maintained with the Illinois federal and state judicial system to resolve problems of a medical-legal nature. Currently being reviewed is the Discovery Deposition procedure, the abuses and excesses evident, and the remedial action outlined in the Resolution of the Chicago Neurosurgical Society, which was endorsed by the House of Delegates in Resolution 63-16. It is hoped that the Liaison Committee of the Bar Association will recommend support of the required changes to the Board of Governors of the Bar Association. This action will provide reinforcement of the Resolution for submission to the Ilinois Judicial Conference and, ultimately, to the Supreme Court of Illinois.

The Committee will continue to pursue these and like activities that will fulfill its responsibilities to the House of Delegates and to the medical profession.

Francis E. Bihss
Leo P. A. Sweeney
Edward C. Helfers
Ralph McReynolds
Charles Allison

COMMITTEE ON MEDICAL TESTIMONY

The basic responsibility of this Committee as established by the Constitution and By-laws is: (1) to confront members who have been "accused of giving improper testimony in court proceedings," and (2) to initiate appropriate action. The Committee realizes that this subject is of vital concern and it points out that it is significant to note and to report that no members of the profession were so accused.

This is the final report of the Medical Testimony Committee as a separate Committee component of the House of Delegates. As stated, the responsibilities vested in this Committee will be absorbed by the Medical Legal Committee. The Committee on Medical Testimony recognizes the value of continued surveillance of medical testimony.

Leo P. A. Sweeney, *Chairman*
Harry D. Nesmith
Joseph F. O'Malley
William H. Schwindel
Peter C. Rumore
Edwin F. Hirsch
John H. Gilmore
Maurice D. Murfin

COMMITTEE ON NARCOTICS AND HAZARDOUS SUBSTANCES

This Committee is fully aware of the serious consequences resulting from the narcotics problem as it pertains to the individual, to the community, and to the medical profession. Drug traffic, medical and socio-economic aspects of the narcotics problem, and rehabilitation efforts aimed at the addict are of vital concern to the Committee.

The Committee continues to study proposals, investigate conditions, explore solutions, and prepare recommendations. During the past year, three important reports on narcotic addiction were reviewed by the Committee:

(1) *Narcotics and Medical Practice*, a report of the AMA's Council on Health, and the National Academy of Sciences—National Research Council's Committee on Drug Addiction and Narcotics, *JAMA*, September 21, 1963.

(2) *Report on Drug Addiction*, The New York Academy of Medicine Committee on Public Health, Bulletin of the New York *Acadmey of Medicine*, July-August 1963.

(3) *Recommendations of the President's Commission on Narcotics and Drug Abuse*, Supplement to *PMA Newsletter*, Vol. 6, No. 4, January 24, 1964.

It was the opinion of the Committee that: (1) the addict is a sick person in need of medical treatment; (2) a unification of medical thinking is basic to establishing a current code of ethical medical practice in the treatment of addiction; (3) the eradication of the profit motive in drug traffic would tend to eliminate illicit distribution channels; and (4) the recommendation of the President's Commission to transfer the control of narcotics from the Treasury Deparmtent to the Department of Justice and the Department of Health, Education, and Welfare needed further study before this Committee could render a proper opinion.

The Committee also considered other addictive and/or habituating drugs such as the barbiturates, tranquilizers, and dexedrine-like compounds. In some areas, an impure dexedrine called "splevins" is being used intravenously. The cost of this substance is relatively cheap. A paranoid type psychosis is produced during the acute intoxicative phase, rather than during withdrawal. The Committee recommended that prescriptions calling for barbiturates, tranquilizers, and dexedrine-like drugs be marked not refillable.

The Committee discussed certain provisions of Illinois bills 14B 644 J., SB-417P, and SB-1146, which are now law. It was pointed out that SB-1146 needs clarifying amendments to protect the constitutional rights of a suspected addict, and also to insure that a confirmed addict receive proper medical attention.

The Committe reviewed the state poison control operation and felt that it was well organized and effectively executed. A special study brought forth a recommendation that Reference Page No. 3 from the Illinois Medical Journal be mailed to every hospital for posting on the bulletin board in the emergency room. Reference Page No. 3 gives a complete listing of poison control centers throughout the state.

A statement of Committee Policy is being prepared for presentation to the House of Delegates.

The Committee feels that continued surveillance and examination of narcotics conditions in cooperation with official and non-official agencies will produce changes that will reduce the high degree of drug exposure.

Ross Schlich, *Chairman*

Earl H. Blair — George S. Schwerin
William U. McReynolds — Joseph H. Skom

COMMITTEE ON OCCUPATIONAL HEALTH

As physicians, we known that the medical specialty of Occupational Health is becoming increasingly significant as an essential ingredient of employee welfare in the continued expansion and diversification of our industrial society. To adequately service this industrial-medical demand for health maintenance of the work force, the Committee on Occupational Health is engaged in projects designed to foster interest in Occupational Health, and to encourage the establishment of like committees in county and branch medical societies.

The signal purpose of this effort is to stimulate —in collaboration with management and labor— the adoption and development of Occupational Health programs in industries, plants, and other organizations which offer employment. Such programs shall seek the improvement, protection, and conservation of health of those employed. The Committee is confident that a well-coordinated state-county Occupational Health Program will make an important contribution to the effectiveness of his medical specialty.

To achieve the goal of greater Occupational Health exposure, the Committee informed county and branch societies about the objectives of the program. The State Commission offered its services in presenting Occupational Health programs at county meetings, and to provide appropriate education materials for the activities of local committees. Initial response to this overture has been gratifying. There is evidence of considerable interest in these activities. Presentations have been scheduled as requested.

The Committee realizes that physicans who are presently working with industrial medicine would prove to be valuable aides in advancing the development of Occupational Health. With this in mind, the Committee contacted the Illinois membership of the Industrial Medical Association. In doing so, the Committee asked these specialists if they would be willing to speak at meetings and agree to sponsor tours of plants which have Occupational Health Programs. Again, the affirmative responses were of such a number that the Committee can

now plan additional educational sessions and orientation tours for component societies.

The Occupational Health Committee continues to pursue these significant activities and to guide educationally and medically the local committees in their efforts that will result in the general improvement of Occupational Health medicine.

Committee: Edward C. Holmblad, *Chairman*

Arthur S. J. Petersen	Fred Stansbury
Milton H. Kronenberg	Myron J. Tremaine
O. W. Rest	Chester R. Zeiss
Edward A. Razim	Henry F. Howe

ANNUAL REPORT PUBLIC AFFAIRS COMMITTEE

By action of the Board of Trustees, January 12, 1964, the Public Affairs Committee was appointed. The Committee held its organizational meeting on February 16, with a new Public Affairs Program subsequently launched.

This committee will ultimately concern itself with all measures for public health, and the education of the public along these lines. Public health matters are usually controlled by public officials. Thus it follows that citizens must be urged to advise their elected officials of their wishes.

The records of the Society show an interest in legislation dating back to 1850. However, a realistic appraisal of current trends and the pressures of vested interest groups, demand greater consideration for the entire field of politics involved. To be successful in legislation, physicians must be concerned with the views of the persons proposed for public office and do their part in helping to select qualified people to represent them in Springfield and Washington. Once elected, the officeholder must be given the necessary backing to retain the office.

The Illinois Medical Political Action Committee (IMPAC) was formed in 1960 to provide a mechanism through which physicians and their allies may participate directly in candidate support. IMPAC was endorsed by the 1961 House of Delegates. By law, this is a separate effort, conducted by physicians as individuals. The funds used in support of political candidates are derived from voluntary contributions, as distinguished from corporate medical society monies. IMPAC endorses and supports candidates on a bi-partisan basis, when medical issues are involved. Restrictions on candidate support do not apply to the development of a general interest in the field of politics by medical societies and other organizations. They do not apply to activities leading up to participation in elections, either through the party-of-choice on general issues, or through IMPAC.

The Public Affairs Program seeks to generate interest in the overall field of politics, enabling physicians to participate effectively. The issues must be thoroughly developed and understood. The reason why participation is necessary must be stated and a knowledge gained as to the manner in which such activities may be carried out.

State:—(1) Continuing educational campaigns to explain the issues and to stimulate public affairs interest, including the publication of a special Public Affairs Newsletter.

(2) Sponsoring of Public Affairs meetings, according to the needs and opportuities presented—ISMS districts congressional districts, stat senatorial districts, etc.

(3) Supplying of speakers and program materials for local meetings.

(4) Field services by staff to implement local programs.

County:—(1) Sponsorship of at least one county medical society Public Affairs meeting each year.

(2) Co-sponsoring and participation in district Public Affairs meetings.

(3) Sponsorship of political education seminars, voter registration campaigns, and other similar projects of a non-partisan nature.

(4) Sponsorship of IMPAC enrollment campaigns and other coordinating functions, not involving candidate support.

John A. Newkirk, *Chairman*

Walter C. Bornemeier	Ted Le Boy
Donald E. Clark	W. Robert Maloney
Justin Fleischmann	John W. Ovitz, Jr.
Theodore Grevas	James D. Roger
C. A. Hedberg	John L. Savage
Edwin F. Hirsch	V. P. Siegel
A. Everett Joslyn, Jr.	Lorin D. Whittaker
Ralph H. Kunstader	Francis W. Young

Liaison and Ex-Officio

Mrs. Fred C. Endres	Frank J. Jirka, Jr.
Mrs. John Van Prohaska	Philip G. Thomsen
J. Ernest Breed	Richard L. Verbic

COMMITTEES ASSIGNED TO DIVISION OF ECONOMICS AND INSURANCE

MEDICAL ADVISORY COMMITTEE TO THE ILLINOIS DEPARTMENT OF PUBLIC AID

Since the 1963 meeting of the House of Delegates, the Committee has met regularly on the Saturday preceding the Board of Trustees meetings. In addition, the Committee has worked day by day through its sub-committees, such as those on Drug Manual, Ophthalmology, Anesthesiology, and by communicating with individual members of the Committee for their recommendation on particular cases submitted to them. Their recommendations

are reported at the next meeting of the full Committee.

During the year the State Legislature established the Department of Public Aid and abolished the Illinois Public Aid Commission. Mr. Harold O. Swank was appointed its director by the Governor. In a letter to Dr. Harlan English, published in the March issue of the *Illinois Medical Journal*, Mr. Swank indicated that he and the Governor looked forward to the continuing services of the State Medical Advisory Committee and its County Advisory Committees. Mr. Swank has indicated to the Committee that there would be no significant changes in the administration of the public assistance program and in the use of the Medical Advisory Committee. He indicated that Committee recommendations would not be delayed as it would no longer be necessary to wait, as heretofore, for the Commission to meet and take official action.

A resolution adopted by the 1963 House of Delegates pointed out the time lag in payments to physicians treating welfare patients and directed the Medical Advisory Committee to bring this to the attention of the Department in an effort to eliminate the delay. When brought before the Department, Mr. Swank informed the Committee of plans for speeding up payment of medical bills, by having bills from physicians submitted directly to the Springfield office where electronic equipment is being installed for the specific purpose of expediting payments. He mentioned that a problem exists when a recipient who gets medical service is no longer a recipient when the bill is submitted for payment 60 days later. He informed the Committee that thought is being given to this problem and that he would like to change the policy so that if a person is a recipient at the time he received medical services the bill will be paid when it comes in—one, two, or three months later. This change is being considered on the basis that the Department has an obligation to insure payment when the County Department authorized the service.

The Committee complied with a resolution passed by the 1963 House of Delegates and pressed diligently for a policy by the Illinois Department of Public Aid which allow equal payments to physicians serving public aid recipients throughout the state whether such service is given in the home, physician's office, hospital, or other institution. Unfortunately no action so far has been taken by the Department on this repeated recommendation. Mr. Swank pointed out that he and the staff had recommended that payment to physicians in Cook County for services rendered to patients in hospitals be made and that a supplemental request was submitted to the Budgetary Commission during the last session of the legislature but was not approved. Mr. Swank is of the opinion that nothing can be done in this Biennium in view of reductions made in the Department's budget request. He did indicate that he would recommend payment to Cook County physicians and would indicate such in his next budget request.

A change in the review procedure of the Disability Program was made by the Department of Public Aid in order to expedite processing and disability determination. In order that such may be expedited, medical data will be forwarded directly to the State Medical Review Team under the supervision of Dr. Reuben Wasserman.

Previously medical factors substantiating permanent disability were examined by the County Medical Advisory Committee. This policy was promulgated by the Department of Public Aid in 1950 when they had no physicians on their staff. Although physicians have been added to the staff since 1950, County Medical Advisory Committees have continued to make the medical review for Disability Assistance cases.

The change in procedure by the Department is being made because applicants and recipients of General Assistance who appear to be eligible for Disability Assistance are being transferred to this program on the basis of "presumptive eligibility." When applicants or recipients of General Assistance are transferred to Disability Assistance, there must be a determination of permanent and total disability within a period of 90 days in order to obtain federal matching funds. The Department of Public Aid pointed out that one of the reasons for long delays in reaching a determination was because cases were being held in the county for review by County Medical Advisory Committees. Hereafter, cases will be referred directly to the Department of Public Aid where the State Review Teams will procede without delay thereby avoiding loss of federal funds.

The Department of Public Aid asked the Committee to recommend a general policy for payment for consultation in addition to payments for other services rendered by the same physician. The Committee deferred its recommendation until such time that it has an opportunity to discuss the matter with other committees of the State Medical Society.

The Committee on Drug Manual will submit a separate report to the House of Delegates. This Committee has done a tremendous job in developing a Drug Manual which will be published and distributed by the Department of Public Aid.

The Medical Advisory Committee is particularly happy to be informed that the Kerr-Mills Program has been extended to provide for the costs of drugs during visits within the 30 days post-hospitalization period; up to 90 days post-hospitalization convalescent nursing home care, including physicians' services and drugs connected with such care; or up to 90 days rehabilitation nursing home care also including physicians' services and drugs. The Committee strongly urges that every physician read the article entitled "Doctor's Guide to Kerr-Mills" prepared by the Division of Economics and Insurance of the State Medical Society, published in the February issue of the Medical Journal. It explains the extension of the AMIA Program; its rules and regulations and is intended to supply

information to physicians without being unduly burdensome. Other brochures are in the process of being developed for public consumption.

The Committee has repeatedly pointed out to the Department of Public Aid that preventive type medicine is important and in the long run would tend to save taxpayers' dollars. The Committee has advocated payment for immunizations and payment for preventive type examinations.

The Committee recommends to the House of Delegates that a wide program of education of physicians on all levels be undertaken to explain the administrative details of the care of public aid recipients.

The Committee recommends that meetings with officials of the county departments of public aid and the local medical societies be set up to see what can be done to smooth the administrative machinery of public assistance programs when necessary.

The Committee recommends that the House of Delegates urge each county medical society to have an Advisory Committee to the Department of Public Aid and to inform the State Society's Headquarters of difficulties or problems encountered at the local level.

The Committee recommends that suggested improvements in procedures be submitted by County Advisory Committees to the State Advisory Committee who in turn will present them to the Department of Public Aid at the appropriate time. The Committee feels that such efforts will greatly aid in making the medical program, administered by the Department of Public Aid, work in the State of Illinois.

The Committee had at all times the full cooperation of the staff of the Illinois Department of Public Aid under the directorship of Mr. Harold O. Swank and his assistants, Mrs. Janet Kahlert and Miss Leslie Freeman. The Committee is particularly appreciative of the excellent help and advice provided by Mr. Walter R. Livingston to the Committee at its meetings throughout the year.

Fred A. Tworoger, *Chairman*
Harry G. McGavran, *Vice-Chairman*

Herbert V. Fine	Robert C. Muehrcke
Walter C. Bornemeier	John H. Steinkamp
Richard Cooper	Chauncey C. Maher, Jr.
Frank B. Norbury	Rex O. McMorris

COMMITTEE ON AGING

The active program of the Committee on Aging has continued during the past year. Emphasis has been placed on further implementation of the stroke program; the preparation, publication, and distribution of a manual to serve as a guide for district and county medical society committees on aging; and orientation of the District Committees on Aging. During the coming year efforts should be directed toward effective implementation of programs at the local and county medical society level.

Stroke and Rehabilitation

The film produced by the Committee on Aging in cooperation with the Illinois Department of Public Health, entitled *Stroke—Early Restorative Measures in Your Hospital* continues to attract considerable interest, both in the United States and abroad. It was shown at several national meetings including the American Medical Association, the National Joint Council to Improve the Health Care of the Aged, the American Congress of Physical Medicine and Rehabilitation, and the American Heart Association. It received world-wide recognition when viewed at the film exhibition of the World Medical Association who awarded the State Society a certificate of participation. In addition to the forty copies purchased by the Illinois Department of Public Health, nearly fifty copies have been purchased by scientific organizations outside Illinois. An article on the Illinois Stroke Program was published in the American Medical Association *Chronic Illness Newsletter* August, 1963.

Rehabilitation Courses

The Committee, in cooperation with the Illinois Department of Public Health, is investigating the establishment of short intensive orientation courses in rehabilitation (five or six days) for physicians. Stipends might be available for physicians attending such courses. The courses would orient physicians in the needs and practical applications of rehabilitation. The Committee recognizes that in most communities the services of a physiatrist are not available and physicians oriented in rehabilitation should improve the rehabilitative facilities and procedures in their areas and hospitals.

Manual on Aging

A loose-leaf manual has been prepared as a guide for our District and County Committees on Aging to assist in implementing program for the aging at district, county, and local levels. The manual includes sections on: (1) Past and present activities of the Illinois State Medical Society Committee on Aging. (2) Organization and programs of district and county committees on aging, including Woman's Auxiliary participation. (3) Rehabilitation and the Stroke Program. (4) Home Care Programs. (5) Physician, Hospital, and Nursing Home Relationships. (6) Programs on Aging of the Illinois Department of Public Health. (7) Methods available for financing health care including private insurance, Blue Cross-Blue Shield, Old Age Assistance, and Kerr-Mills. (8) Community programs sponsored programs by county medical societies. (9) Appendix including reference material.

The Committee expresses appreciation to those Committee members and staff who prepared sections of the manual and also to Mrs. John Van Prohaska, Chairman of the Woman's Auxiliary Committee on Aging; Miss Dorothy Campbell, Coordinator of the Peoria Home Care Program; Mrs. Jeannette Kramer, President of the Illinois Nurs-

ing Home Association; Miss Aileen Hoffman, Illinois Department of Public Aid, and Mr. Nick Griffin of the American Medical Association, for their written contributions or for providing pertinent material. The manual was distributed to the chairmen and members of the district committees, each county medical society, and each officer and member of the Board of Trustees.

Meetings have been held or scheduled with each district committee to discuss the program and urge immediate implementation at the county medical society level. Participation in the program by the Woman's Auxiliary is particularly being encouraged.

Television Program

The Board of Trustees of the Illinois State Medical Society, upon the recommendation of the Committee, approved in principle a proposed project of the Chicago Educational Television Association for "demonstration of the use of television as a medium of education in the home care of the chronically ill and disabled," and authorized the Chairman of the Committee on Aging, or his representative, to serve on the advisory council of the project. The proposed programs will be directed toward families caring for patients at home. The co-director of the proposed project is Dr. Edward Gordon, a member of the Committee on Aging.

National Conferences and Miscellaneous Activity

The Committee was represented at two national conferences held in Chicago in January and February, 1964. The AMA Committee on Aging sponsored a conference discussing a paper on long term care being prepared by the committee. Representatives of national organizations concerned with long term care were invited to participate. The Chairman of the Illinois State Medical Society Committee on Aging, as a consultant to the American Medical Association on Aging, was asked to attend. Dr. Henry T. Ricketts represented the Committee at the 13th Annual Meeting of the National Council on Aging.

The Committee supports the action of the National Council for Accreditation of Nursing Homes in the new accreditation program. The Council was established by the American Medical Association and the American Nursing Home Association. Doctor H. Close Hesseltine has been appointed Chairman. The Committee recommends that county medical societies encourage nursing homes to apply for accreditation.

The American Medical Association Committee on Aging is planning further regional meetings in 1964 and 1965. The Committee will be expected to cooperate with the American Medical Association Committee on Aging in holding a regional meeting for the states, including Illinois.

The Committee on Aging recommends that major emphasis during the coming year be directed toward implementation of county medical society programs described in the manual through active encouragement and assistance of the Illinois State Medical Society Committee on Aging and District Committees on Aging. Effective implementation of the county programs will require the appointment of active committees on aging by all county medical societies.

The Committee desires to acknowledge the invaluable services of Mr. Walter R. Livingston for his assistance and cooperation in the preparation and publication of the manual and in the implementation of all programs of the Committee.

Edward W. Cannady, *Chairman*

Preston V. Dilts	Lawrence J. Rossi
Edward E. Gordon	Martin H. Seifert
Joseph R. Mallory	Roger F. Sondag
Ernest G. McEwen	Thomas T. Tourlentes
Michael R. Saxon	Henry M. Wilson, Jr.
Henry T. Ricketts	

Auxiliary: Mrs. John Van Prohaska

LIAISON COMMITTEE TO BLUE CROSS—BLUE SHIELD

No report to be submitted.

COMMITTEE ON FEE SCHEDULES

Two principle areas of concern occupied the Fee Schedules Committee's attention during the past year: (1) the 1963 action of the House of Delegates relevant to non-service connected disabilities treated in VA hospitals; and (2) outlining plans for renegotiating the Dependents' Medical Care Contract.

The 1963 House of Delegates recommended that VA hospitals provide care only for service-connected disabilities except in those instances where veterans are financially unable to pay for medical care and hospital services as proven by a means test. The Committee is aware that the State Medical Society as well as the American Medical Association have reaffirmed their position on this matter over the past several years.

The Committee recommends that the Illinois State Medical Society take the position that:

(1) Veterans Administration facilities should be used only for the care of service-connected diseases and disabilities;

(2) that the care of non-service connected conditions should be the responsibility of the individual, or, if he is medically indigent, of his community or state;

(3) where care is provided in VA facilities for non-service connected illnesses or disabilities, it should be provided on the basis that the individual if financially unable to pay for this care outside of veterans' facilities, thereby indicating medical indigency proven by a means test; and

(4) that a resolution be prepared and submitted by the Illinois Delegation to the American Medical Association's House of Delegates incorporating these recommendations and bring them to the attention of the appropriate government agency.

Medicare

At the present time, the Committee is in the process of developing plans for renegotiating the Medicare contract in July, 1964. There are areas in which the provisions under contract may be improved and such recommendations, when finalized, will be brought to the attention of the appropriate body of the State Medical Society for is approval.

For the twelve months ending December 31, 1963, a total of 6,876 military dependents in Illinois were served. Payments to physicians totaled $594,552.86. A breakdown of the cases is as follows:

Obstetrical and maternity	3,387
Premature care	70
Normal newborn care	392
RH factor, babies (exchange transfusions)	11
General medical care	1,216
Fractures	144
Other bodily injuries	207
Gynecological surgery	216
Other general surgery	667
Anesthesia claims	564
Total	6,876

The Illinois Medical Service (Chicago Blue Shield) continues as fiscal administrator handling administrative details of the program.

The Committee is in the process of reviewing fee schedules and schedules of allowances used by various agencies within the state except those which apply directly to a specific Committee and is contemplating a meeting with the Division of Vocational Rehabilitation April 5, to discuss revision in their schedule of allowances.

The Committee recommends that members of the Illinois State Medical Society provide the best type medical care to individuals covered by fee schedules negotiated and approved by the State Society's House of Delegates and/or the Board of Trustees, and accept payment based upon the approved fee schedule. It further recommends that no individual or committee of the State Medical Society be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted and approved by the House of Delegates and/or the Board of Trustees.

Whereas fee schedules are necessarily variable and of a temporary nature, established to respond to a specific need at a particular time, the Committee further recommends that the schedules be reviewed and revised at appropriate intervals in order to reflect actual practice.

Selective Service

With the Department of Defense requesting 22,300 men for army service during March, 1964 indicates that there will be an increased need for physicians. At present there is a call for 1,050 physicians—650 for the Army and 200 each for the Navy and Air Force. The Illinois quota is 88. These 88 physicians will be order for induction as of July 1, 1964 and will be for men completing internship who were born on or after July 1, 1935.

The Department of Defense, in announcing the call, said it was necessitated by the fact that insufficient numbers of 1963 medical school graduates volunteered for active duty immediately following internship.

The majority of physicians who enter service as a result of the draft will serve as general duty officers. The need for specialists in the Armed Forces Medical Services is filled with volunteers who were deferred for specialty training under the Berry Plan, and those completing their military residencies.

Interns are to be allowed to complete their internship even though commissioned prior to completion.

George F. Lull, *Chairman* — C. Elliott Bell
Franklin J. Moore — Percy E. Hopkins
Maurice M. Hoeltgen — Carl F. Steinhoff

COMMITTEE ON HOSPITAL RELATIONS

The Fifth Annual Joint Conference sponsored by the Illinois State Medical Society and the Illinois Hospital Association was held in Peoria in September, 1963. It was co-sponsored by the Illinois Department of Public Health inasmuch as the Conference topic was "Comprehensive Care in the General Hospital." The approximately 300 registrants were mainly hospital administrators, trustees, chiefs of staff and directors of nursing service. The morning session was presided over by Leonard P. Goudy, IHA Co-Chairman, and had as its main speakers Dr. Frank H. Krusen, Professor, Temple University Medical Center, Philadelphia; Henry B. Betts, M.D., Rehabilitation Institute, Chicago; and Henry Mason Wilson, Jr., M.D., Methodist Hospital, Peoria. The afternoon session was divided into eight workshops, each of which was presided over by an outstanding leader.

In February, 1964, the Committee met with the Hospital Association to lay down plans for its sixth annual joint fall conference and agreed that the topic will be "The Economics of Hospital Care."

The Committee discussed hospital emergency room services and the importance of educating the public on the proper use of the community hospital emergency service. The Committee agrees that two points need to be stressed: (1) the family physician should be contacted for his instructions before rushing to the hospital; and (2) patients should be made aware that both hospitals and physicians charge for emergency room service; that Blue Cross pays for hospital service only in cases of "surgical" and not medical emergency.

The Committee discussed at length the Department of Registration and Education's forthcoming survey questionnaire to hospitals to determine the license number of all practicing physicians in Illinois and the number of unlicensed medical school graduates employed by hospitals.

The Committee is continuing to lend assistance to the Hospital Association in an effort to achieve

accreditation for non-accredited hospitals. A few hospitals still remain unaccredited.

The Committee recommends to the House of Delegates continued cooperation with hospital administrators in solving mutual problems pertaining to the following:

(1) Utilization of beds and other facilities; and restates the policy adopted in February, 1962, of the Illinois State Medical Society:

"The utilization of inpatient services and diagnostic facilities within the hospital is the responsibility of hospitals, the medical profession, the individual patient, as well as third parties, namely Blue Cross, insurance carriers, labor and management.

"Since the direct provision of services is and must be under the management of the physicians, the hospital staff is urged to establish a utilization committee, composed of medical staff members and administrator to examine all factors influencing hospital utilization, and that these factors be made known to the entire medical and hospital staff.

"It is further suggested that an educational program be developed to promote understanding of the relationship between the consumption of hospital and medical services and the cost of prepayment and insurance plans."

(2) Medical, nursing, and administrative care of patients;

(3) Hospital costs;

(4) Accreditation of non-accredited hospitals.

The Committee further recommends that the representatives of hospital medical staffs have free and direct access to the hospital's governing board, with due consideration to the hospital administrator's position as chief executive, in order to improve physician-hospital relationships in the interest of patient care by seeking full cooperation among medical staffs. Such access may be developed along the following lines:

(1) The Executive Committee of the medical staff and the committee of the governing board of the hospital administrator can serve as a joint committee;

(2) Representatives of the medical staff can serve as members of the medical staff committee of the governing board with the hospital administrator;

(3) Representatives elected by the medical staff can attend meetings of the hospital governing board, and in turn, representatives of the governing board can attend medical staff meetings with allowances made for executive session.

The Committee further recommends that evaluation of the chief of service and members of the medical staff should be the responsibility of the medical profession. The principle of the freedom of the staff to make recommendations concerning staff appointments and privileges should be recognized subject to the approval of the hospital's governing board.

The Committee further recommends that a committee be available at the county level to serve as liaison with hospital representatives and to review mutual problems.

Finally, the Committee recommends that the State Medical Society undertake to educate the public concerning the difference between the term "health care costs"—being all inclusive—be used instead of the term "medical care costs."

Noel G. Shaw, *Chairman*	N. A. Thompson
E. A. Piszczek	John A. Bowman
J. W. Buser	John M. Dorsey

COMMITTEE ON MEDICAL ECONOMICS

Your Committee sent representatives to Washington who appeared before a United State Treasury Department Committee and spoke in protest against the proposed amendments to the regulations under Section 7701 of the Code. These proposed amendments would make it literally impossible to claim tax status as a corporation, even though such corporation was legally constituted under the State Act.

There have been three meetings held so far of this Committee and at least one more is planned before the annual May meeting.

The Disability Insurance Program enrollment was increased by virtue of increasing benefits to the members. Several group retirement income plans were studied at length; however, since none of these have been Keogh-qualified, we have not yet recommended such a plan to our members. If a conclusion is reached in our final meeting of the year, your Chairman will submit a supplemental report at the May meeting.

A report to the membership at large appeared in the December issue of the IMJ in which we advised that those physicians who wished to go into a Keogh-qualified plan in 1963 make prompt application for the AMA plan.

In summary, your Committee feels that the present status of HR-10 is still not clear and that the future status is even more uncertain. Clearer interpretation of the regulations and some possible changes in the law itself may well be forthcoming, which will probably liberalize the present provisions. This Committee should continue in its efforts to help establish sensible regulations of the Treasury Department regarding medical corporations, and should also study the establishment of medical foundations. Further group insurance programs should be developed and offered to the membership.

We propose that the future activities of this Committee include the following items:

1. Continuation of the efforts to make possible the fullest use of the Act authorizing the formation of medical corporations, so that coroprate benefit may be utilized by our members.

2. Continuation of the investigation of various insurance programs, including major medical and comprehensive hospital group type policies.

3. Consideration of the possible formation of medical foundations by interested groups within our membership.

I would like to thank sincerely the members of my Committee for their lively interest and dedicated attention.

I. Erlin Bartlett, *Chairman*

Norris L. Brookens	Robert E. Schettler
Maurice M. Hoeltgen	J. A. Stocker
John J. Holland	Philip C. Lynch
Clifton L. Reeder	Frederick Z. White

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS

Two principle areas of concern occupied the Committee's attention since the 1963 meeting of the House of Delegates: (1) a suggested Guide for Presentation of Cases for Review, and (2) the HIC Comb-1 claim reporting forms project started in 1961.

Over 198,000 copies of the HIC Comb-1 claim form have been distributed since the initial mailing to Illinois physicians in April, 1961. These forms, in pads of 50, continue to be available without charge as long as the supply lasts. Requests should be directed to the Chicago office of the Illinois State Medical Society.

In keeping with the directive of the 1963 House of Delegates, the Committee recommended to representatives of the Health Insurance Council that the form be revised by clarifying what is wanted in the medical section; that release for medical information be included; and also that the form allow for the assignment of benefits.

The Committee recommends to the Illinois State Medical Society that a resolution be prepared and submitted by the Illinois Delegation to the American Medical Association House of Delegates incorporating these recommendations.

An objective of the Illinois State Medical Society program is to achieve compliance from the insurance industry in the use of standard insurance forms agreed upon at the national level. These bear the HIC seal, identifying all standardized forms. If physicians will insist, it is envisioned that all forms submitted by all insurance carriers will eventually bear the HIC seal, indicating conformance with the approved procedure. To gain further uniformity, Illinois physicians are being asked to complete the form presented by the insurance company when it bears the HIC seal and when it does not bear the seal, submit a completed Comb-1 form and attach it to the blank non-approved form. When an insurance company insists upon completion of a non-approved form an extra charge by the physician is warranted.

District Chairmen of the Prepayment Plans and Organizations Committees were contracted by telephone to determine (1) if they wished a meeting with the State Committee before the Annual Meeting in May and (2) what activity, if any, there had been during the year with regard to grievances and review.

It was the consensus that a meeting with the State Committee was not necessary inasmuch as the District Committees had been relatively inactive during the past year. It was reported that grievances filed with District Committees had been resolved without difficulty to the satisfaction of those concerned.

District I reported that its Committee is vitally interested in developing a major medical plan for its members. The Committee was informed that major hospital and nurse expense coverage is available to members of the State Society on a group basis, although not officially approved by the State Medical Society, and information pertaining to that program was forwarded to the Chairman of the Committee for examination.

District II reported that the Committee is attempting to work out a plan for postpayment of medical care. This is being worked out jointly with banks in an effort to obtain bank financing for the care received. It is patterned after a dental plan now existing in the area whereby the dentist is paid by the bank and the patient signs a note and pays the bank on a regular installment basis. The loan is not guaranteed or secured by the dentist nor is there intent by the physicians of the district to guarantee bad debts.

The remaining districts reported no activity during the year.

The State Committee reviewed the possibility of developing a guide for the presentation of cases to the Committee for review. It was suggested that the guide include the function, source of inquiry or complaint, procedure to follow, and Committee action. The Committee is of the opinion that this will serve to expedite review cases and recommends that this project be pursued by the Committee and upon completion distribute it to District Committees and their members.

Maurice M. Hoeltgen, *Chairman*

Harry Mantz	E. Lee Strohl

COMMITTEE ON REHABILITATION SERVICES

The Committee on Rehabilitation Services is in the process of preparing a brochure which will be distributed to all physicians containing information regarding types of disabilities amenable to rehabilitation and available rehabilitation facilities in the state. Periodic revisions will be made by the Committee in an effort to keep the brochure current.

The Committee has considered the relative merits of establishing District and County Committees on Rehabilitation Services and postponed action until such time as the Committee has set forth its rehabilitation program and outlined specifically what can be done at the grass-roots level. The Committee will work closely with the Governor's Committee on Employment of the Handicapped when called upon for its advice and counsel.

The Committee recommends to the House of Delegates:

(1) That all physical rehabilitation activities be specifically prescribed by a physician and the treatment carried out under the supervision of a physican;

(2) That the State Medical Society render assistance to public and private agencies in the establishment of policies regarding rehabilitation facilities to be used and selection of patients for these services;

(3) That the State Medical Society assist when possible to see that adequate medically supervised rehabilitation services be made available in all hospitals, according to the need of the hospital, in order to start early rehabilitation thereby preventing unnecessary disabilities during the acute stage of illness;

(4) That the Society encourage the training of rehabilitation personnel, including therapists, nurses, nursing aides, social workers, vocational counselors, etc., thereby promulgating high quality care and helping in the implementation thereof when called upon to do so.

Since rehabilitation services are organized medical services performed in qualified institutions and hospitals, the Committee strongly recommends that the insurance industry be urged to include rehabilitation services in their contracts and that this be brought to the attention of the appropriate committee for implementation.

Edward L. Compere, *Chairman*

Paul Richard Allyn	Daniel Ruge
Rex O. McMorris	Reuben R. Wasserman
Harry Phillips	Howard W Schneider

COMMITTEE ON RELATIVE VALUE

The Relative Value Committee has revised, edited and published the Relative Value Study, as directed by the House of Delegates. Distribution will be made before the 1964 Annual Meeting.

The Committee also has prepared the following recommendations regarding relevant policies:

1. Policy regarding adoption of co-efficient:

The Relative Value Committee recommends the adoption of a *firm* policy NOT to establish any co-efficient whatsoever at the state level, either now or in the future.

Comments: Such a policy should not be construed as prohibiting use of data contained therein for developing fee schedules by the State Society's Fee Committee, or by county medical societies for a similar purpose. Nor should it prohibit appropriate use by grievance or prepayment committees within the State of Illinois.

2. Policy relative to distribution outside of the membership of the Illinois State Medical Society:

a. The Committee recommends a policy sanctioning distribution on request to component members of the American Medical Association; to specialty societies and associations, to the American Academy of General Practice, and to their component satellites.

Comments: Free exchange of information and ideas regarding relative value studies has already become an established practice among medical societies at the county, state and national levels. The Illinois State Medical Society has a very definite obligation to share its experience with its sister organizations.

b. The Committee recommends the formulation of a policy which will permit distribution on request to third-party purveyors of health care services, *subject to individual consideration in each case.*

Comments: It is fallacious to assume that distribution to third-parties can be prevented either by a policy statement or by any other means available to the Illinois State Medical Society. There are too many sources from which copies can be indirectly obtained.

It would therefore seem more practical, and also more politic, to distribute copies on request, subject to individual consideration in each case.

Precedents for such a policy have previously been established in all states in which similar studies have been conducted. There are many other facets to this problem, all of which support the formulation of a policy sanctioning distribution.

3. Policy regarding revisions:

The necessity for keeping the Relative Value Study up to date is obvious.

Any given study is obsolescent by the time the survey is completed and the study itself is approved and published, and it becomes progressively more obsolete with each passing year. In present day inflationary economy the life-span of any study is approximately four years.

The Illinois Relative Value Study was initiated in 1961. The preliminary version was published in 1962. It was approved, with revisions, in May 1963. The first approved edition will be published and distributed in early 1964. It is therefore somewhat obsolescent.

Recommendation: The Committee recommends that revision of the Relative Value Study be effected at appropriate intervals, on recommendation of the Relative Value Committee and approval of the Board of Trustees, as a matter of policy.

The Committee further recommends that specifications relative to methods be excluded from policy statements.

4. Professional education:

A policy statement should be formulated to establish responsibility for this activity.

Comments: Unless the Relative Value Study is widely and properly use, the entire investment will have been wasted. The need for such a study was clearly established prior to its inception. It is no less today than in 1961. Quite to the contrary.

Professional education will involve multiple individuals and committees within the State Society as well as the Relative Value Committee. For this reason, responsibility for leadership should be fixed, and a policy statement to this effect should be formulated

A supplementary report will follow.

C. Elliott Bell, *Chairman*

Walter C. Bornemeier	Joseph G. Gustafson
John F. Eggers	Franklin J. Moore
R. Gregory Green	Max S. Sadove
Gershom K. Greening	T. J. Wachowski



COMMITTEES ASSIGNED TO DIVISION OF PUBLICATIONS AND SCIENTIFIC ACTIVITIES

EDITOR, ILLINOIS MEDICAL JOURNAL

Several personnel changes in the Journal editorial staff were made during late 1963 and early 1964. In October, 1963, assistant editor William E. Anderson was transferred to the ISMS public relations staff. To fill the vacancy thus created, Miss Joanne Twomey was moved up from her position as editorial assistant. In January, 1964, Robert J. Zavrel replaced Miss Twomey, who had resigned.

A total of 103 medical articles were published in 1963. Of these, 63 were standard clinical papers, 10 were Dr. Leon Love's *View Box* presentations, and seven were "outdoor medicine" features written by Dr. Julius Kowalski. In addition, 23 editorials dealing with medical subjects were published.

During the first three months of 1964, 22 clinical papers and three *View Box* features were published. The serialized *History of Neurology in Chicago*, authored by Dr. Roland Mackay, was begun in January, 1964.

A new development being planned for 1964 is the proposed "Medical Intelligence" series. Prominent authorities in the various medical specialties have been invited to participate in this project. Each authority has been asked to contribute a short review of the latest significant advances that have taken place in his particular specialty.

I would like to take this opportunity to thank Mr. Albert G. Boeck, Jr., Director of Publications; Mr. William E. Anderson, who served as assistant editor; Mr. Robert J. Zavrel, the present assistant editor; Miss Maureen McCarthy, the editorial assistant; and Mr. John A. Kinney, business manager, for their diligent and constructive efforts during the past year.

T. R. Van Dellen, M.D.,
Editor, Illinois Medical Journal

EDITORIAL BOARD

The Editorial Board held several meetings in 1963, the last on October 2, 1963, with the Editor and staff of the *Illinois Medical Journal*. The relationship between the decline in advertising and the size of the Journal was explained and other problems were discussed.

Although it is not now possible to expand the volume of the Journal, the Board felt the quality of the articles might still be raised without any additional expense.

The problem of the backlog of articles was presented by the Editor. The Board expressed the desire to see the backlog to help evaluate the manuscripts. It also indicated a desire for a more active role in determining the content of the Journal.

A motion was presented to the Board of Trustees requesting that the Journal be given adequate budget and staff necessary to the maintenance of the highest standards.

Various members of the Editorial Board expressed dissatisfaction with some of the editorial material and other items in the Journal. State medical society journals, as a rule, do not enjoy the esteem accorded specialty and national medical journals. The Illinois State Medical Journal is recognized as one of the better state society journals.

A rqeuest by the Editorial Board was made to the doctors, particularly in the state of Illinois, to submit their manuscripts in research and clinical studies for consideration for publication in the Illinois State Medical Society Journal, thus to enhance the scientific stature of the Journal.

Samuel A. Levinson, *Chairman*
James H. Cross
Frederick H. Falls
Edwin F. Hirsch
James H. Hutton
Harvey Kravitz
Julius M. Kowalski
Francis L. Lederer
Charles Mrazek
Clarence J. Mueller
Jacob E. Reisch
Arkell M. Vaughn
Edward F. Webb
John R. Wolff

JOURNAL COMMITTEE

During the year the Journal Committee worked in close collaboration and harmony with Dr. Theodore Van Dellen, editor; Mr. Albert Boeck; and members of the *Journal* staff on problems concerning publication of the *Illinois Medical Journal*.

Several meetings of the Committee were held, with the staff attending, to consider proposals and recommendations to maintain standards of excellence despite a continuing down-trend in advertising income.

Despite the decline in advertising, a number of improvements were made in the *Journal*—all within the budget. These included adoption of the new

cover design, addition of the *Legislative Listening Post, Pulse* section dealing with public relations activities of the Society, and typographic refinements for a more informative and attractive publication.

We are not plannng any major renovations in the design of the *Journal* during 1964. The policy of operating on a conservative budget, comparable to that of 1963, will be continued. A budget of $102,000 has been presented and approved by the Board of Trustees for the year.

The budget is based on the premise that we cannot anticipate a "loosening-up" of advertising by the major drug companies as far as the state medical journals are concerned. There appears to be little promise that a new cycle of ethical drug products will be introduced because of the restrictions of the new drug law. This means that advertising revenues will certainly not increase. Under these conditions, most of the larger pharmaceutical companies are spending the largest part of their advertising budgets in the national publications. We are not alone with our advertising income problem. All of the state medical journals are experiencing severe reversals.

Income of the *Journal* in 1963, including advertising, sale of reprints, and non-member subscriptions, was $79,875. The projection for 1964 is $75,000 in advertising, plus income from reprints and non-member subscriptions which cannot be predicted at this time. We anticipate an income year similar to 1963, with this exception: an advertising rate increase effective in January of this year is expected to add to our dollar volume net. It is difficult at this stage of the advertising year to predict how much this dollar volume will increase. The rate increase for all advertisers averages 15 per cent higher than in it did '63.

Printing expenses and production of the *Journal* were reduced by $6,000 from 1962. The budget was reduced from $108,000 to $102,000. Of the $25,000 initially allocated by the Board to the *Journal* budget, approximately $3,000 was not used. This was returned to the general fund. This amount would have been higher were it not for a budget appropriation to the Journal Readership Survey. The cost of this survey is covered in most part under the 1963 budget. An independent research firm is now working toward completion of the Readership Survey data. We expect to have the statistics and results available for a report to the membership before our annual convention.

The mailing of the survey form was made to the entire membership. There were 3,178 members who completed and returned the questionnaire. This is considered an excellent percentage without resort to sampling techniques, phone calls and other follow-ups.

Relative to the earlier reference to advertising income to off-set operating costs, there is a disturbing trend difficult to cope with, that the Committee and *Journal* staff has under surveillance.

This is the present trend of the largest pharmaceutical firms to advertise in the national medical journals and other media, while minimizing their expenditures in the state medical journals.

Part of this is based on what the companies and advertising agencies call "cost per-thousand circulation." We have indeed entered the computerized stage of basing advertising costs on circulation and numbers of readers reached in terms of advertising dollars expended. Our main forte is proving reader interest in our own publication.

To help broaden and strengthen the image of our *Journal* as a major publication in the Midwest, Mr. John Kinney, our business manager, has been instrumental in organizing an institutional federation of the largest independent state and regional journals, including *New York State Journal of Medicine, California Medicine, Southern Medical Journal, Illinois Medical Journal, Northwest Medicine* and *Rhode Island Medical Journal.*

The purpose, for the time being, is to emphasize the medical importance of the geographic areas that the journals serve as official publications of their societies. A cooperative advertising program in underway with one-third pages in *Standard Rate and Data.* Meetings between the business and advertising managers of these journals have already served useful purposes. Promotional ideas designed to acquaint to companies and agencies with the importance of journals in their areas have been exchanged. The relative savings in advertising dollars when using these journals compared with the national publications has been emphasized.

Two matters of policy on the *Journal* were considered by the Board during the year and a proposal to publish a Membership Handbook has had a favorable reaction by the Finance Committee.

(1) Action of the Board of Trustees, January 12, determined that the Journal Committee should be responsible for the entire publication policy. In this respect the Editor of the *Journal* should report to this Committee. It was also agreed that inasmuch as the Journal Committee is constituted of members of the Board of Trustees, the Committee should recommend to the Chairman of the Board of Trustees the names of those to be appointed to the Editorial Board.

(2) On January 12 the Board of Trustees directed the Journal Committee and the Committee on Scientific Assembly to study the proposal that the *Journal* refrain from carrying any further ads for cigarette companies. Also, that no exhibit space at the annual convention be sold to cigarette companies. The two committees are to report their recommendations to the Board for action.

The January 11 proposal by Mr. R. L. Richards, executive administrator, on publishing a Membership Handbook issue in 1964 as part of a regular issue of the *Journal*, received favorable consideration by the Finance Committee. The handbook would contain all the basic information which members should know about the Illinois State Medical Society, such as insurance programs, how to handle public assistance cases, membership requirements and application procedures, legal problems, etc.

With the present capabilities of the *Journal*

staff and the interest all have shown toward a common goal, the Journal Committee looks forward rather optimistically, despite problems and obstacles, to an improved IMJ in 1964 and future years.

Jacob E. Reisch, *Chairman* — Frank J. Jirka, Jr.
J. Ernest Breed — B. E. Montgomery

THE EDUCATIONAL AND SCIENTIFIC FOUNDATION

In addition to administering the Impartial Medical Testimony Program, two other important projects were carried on under the auspices of the Foundation during the past year.

Water Project

A study was instituted to investigate contradictory reports regarding the relationship between soft water and heart disease which are appearing in the literature. This study was conducted under the direction of Dr. James Wilson. The report was published in the January issue of the *Illinois Medical Journal*. The following served as consultants for the study: Dr. Abel Wolman, Johns Hopkins University; Dr. William Strain, School of Medicine and Dentistry, University of Rochester; Dr. W. H. Sebrell, Jr., Columbia University Institute of Medical Science; Dr. Oglesby Paul, Passavant Memorial Hospital; and Dr. John Dingle, Preventive Medicine, Western Reserve University.

Multiple Birth Film

The Foundation was approached by Doctors Allen Charles and William Alpern—the attending obstetricians at the birth of quadruplets in Chicago last year—to discuss the possibilities of a teaching film on the management of multiple births. Dr. Norman Brill had photographed the delivery in color and the three men thought that this would make an excellent nucleus for a film. The film would emphasize the protocol for necessary prenatal care in multiple births, and it would present laboratory procedures for the establishment of identicalness. Lederle Laboratories agreed to sponsor the film with a grant and the production of the film is now underway.

Grant to Sangamon County

A grant of $500 was made to the Sangamon County Medical Society in support of a community health survey.

Honorary Fellowship

Judge Robert Hunter was presented with an honorary fellowship in the Foundation at a joint meeting of the Adams County Medical Society and the Adams County Bar Association. Judge Hunter is a strong advocate of IMT.

Speakers Bureau

Merck, Sharp & Dohme made two grants, totalling $3,250, in support of the Scientific Speakers Bureau operated by the Committee on Postgraduate Medical Education and Scientific Service. This program provides physician speakers for county medical society meetings.

Medical Self-Help Training

The Foundation received $10,000 from the Illinois Department of Public Health in support of a series of television programs on medical self-help training produced by the ISMS public relations division.

Note of Gratitude

The Trustees of the Foundation wish to express their gratitude to the Eli Lilly Foundation for its grant in support of IMT; to the ISMS Committee on Aging for turning over the proceeds from its film to be used for future projects on the problems of the aging; and to the Trustees and staff members who generously contributed to become fellows of the Foundation.

The Foundation Trustees is appreciative of the work of Mr. Al Boeck and his assistants who have carried on the day to day work of the Foundation in a highly satisfactory manner.

George F. Lull, *Chairman*
Newton DuPuy — E. A. Piszczek
Harlan English — Jacob E. Reisch

CANCER CONTROL

Report not available at publication time. Please check handbook index for late reports.

CARDIOVASCULAR COMMITTTEE

The Cardiovascular Committee met with the Professional Education Committee of the Illinois Heart Association on January 9, 1964. The following report is the result of this meeting and also of a number of subsequent discussions with members of the committee through the year. Some matters of interest were as follows:

(1) In the field of rheumatic fever, more progress is being made in the extension of the thorat culture program to a greater number of schools in the state. First attacks and recurrences could be reduced—possibly to the vanishing point—if this program were given the degree of attention enjoyed, for example, by the polio immunization program.

(2) Some thought has been given to urging hospital administrators to consider activating intensive care areas in their hosptals for the treatment of myocardal infarction cases. It is felt that a definite overall reduction of morbidity and mortality would result.

(3) There is little doubt that many lives would be saved by having an external defibrillator situated in every hospital in the state. Training of key personnel in the use of the defibrillator, along with instruction in the technique of closed chest cardiac resuscitation, should have a high priority. In addition, the recent introduction of the cardioverter has added a great deal to the armamentar-

ium of the correction of cardiac arrhythmias. At present, the Illinois Heart Association is conducting a survey to determine the number of Illinois hospitals that have these machines and the necessary personnel trained in their use. The Heart Association offers to help in such training if it is requested.

(4) The University of Illinois School of Nursing presented a series of lectures covering the modern nursing care of cardiovascular patients to graduate nurses. The latter, in turn, have passed this information on to nurses in their own areas.

(5) There is a recognized need for a greater effort to be made toward continuing education of physicians in the field of cardiovascular diseases. The fact that approximately $100,000,000 is being spent yearly on research by the National Heart Institute, the American Heart Association, and many of its affiliates makes it paramount that the fruits of this research be brought to the practicing physician. Some of this work is being done in Illinois by the Chicago and Illinois Heart Associations through scientific meetings and the distribution of the *Heart Journal* and *Modern Concepts of Cardiac Diseases*. The Academy of General Practice helped by the inclusion of cardiovascular subjects in its courses. However, a great deal more must be done in this field of translation of research successes to the better care of patients suffering from cardiovascular disease.

Arnold S. Moe, *Chairman*

Wright Adams	A. Paul Naney
Hugh Espey	Oglesby Paul

CHILD HEALTH COMMITTEE

The Child Health Committee studied the problems of the physically abused child. It considered the question of whether ISMS should sponsor legislation requiring that instances involving physically abused children be reported. This consideration passed the questions of who should report such instances, and the legal problems involved. The Committee recommend that the *Suggested Language for State Legislation on Reporting of the Physically Abused Child* of the Children's Bureau of the Department of Health, Education and Welfare, be endorsed. Also, that the following points be included in any proposed legislation which should be drafted by the Commission on Children: (1) That every consideration for the immediate safety and subsequent care of the child be given; (2) that there be provision for restraint and rehabilitation of the abusers; and (3) that there be provision for research in this area. The Board of Trustees approved the Committee's recommendation.

Dr. Fred P. Long, Chairman of the Sub-committee on Immunizations, reviewed the measles situation. The Committee recommended that the ISMS endorse the immunization recommendations of the Committee on Infectious Diseases of the American Academy of Pediatrics as a guide for all physicians in Illinois. It further recommended that all physicians keep the statuses of their patients' immunizations current. The Board approved this recommendation also.

Having previously approved both the live and inactivated measles vaccines, and being on record in favor of the immunization of children susceptible to measles, the Committee is now concerned about protection for children whose families are unable to pay for vaccine

The Committee does not advocate a mass measles vaccination program. It steadfastly adheres to the principle of having patients treated by private physicians in their own offices. Nevertheless, the Committee recognizes the need for funds to enable the State Department of Public Health to provide measles vaccine for indigent families. Therefore it recommended that the ISMS initiate and support appropriate action which would enable the Department of Public Health to make measles vaccine available to physicians on request for the non-immune indigent child. At its February 18 meeting, the Chicago Pediatric Society independently passed a similar resolution drected to the Chicago and Cook County Boards of Health.

The Committee reaffirmed its view that the health appraisal of school children should be performed by the family physician or pediatrician. Further, that this should be done in the physician's office or clinic, and not in school.

The Sub-committee on Fetus and Newborn has been active in educational programs throughout the State. Dr. H. F. Philipsborn, Chairman, reported on satisfactory progress being made in the Perinatal Mortality Pilot Study.

Dr. W. W. Fullerton is programming a symposium on medical aspects of sports. He was authorized by the Committee to explore a possible program emphasizing athletic injuries to be sponsored by the Illinois Joint Commission on School Health and the University of Illinois Athletic Department.

Dr. Dukes reported that there has been difficulty in the formation of school health councils. He urged that all physicians who are on school boards persuade superintendants to set up councils.

After considerable deliberation on the problem of smoking by youths, the Committee recommended that ISMS promote a continuing, aggressive program aimed at preventing children from starting to smoke and to influence teen-agers who already are smokers to discontinue the habit The recommendation suggested that ISMS makes these policies known to all physicians and residents of Illinois by all appropriate means. The Board approved this recommendation. The Committee also recommended that all commercial tobacco exhibits at annual conventions and tobacco advertising in ISMS publications be disapproved. This recommendation was referred to the Committee on Scientific Assembly and the Journal Committee for consideration.

Dr. Danely P. Slaughter, President of the Illinois Division, American Cancer Society, asked for a representative from ISMS to an Illinois Coordinating Committee on Smoking and Health to

discuss cooperative programming and to seek ways of combating the health problem of smoking through combined efforts. Dr. Fred P. Long was approved as the representative.

Dr. Kenneth S. Nolan was appointed representative to State Cooperating Organizations to the Illinois Commission on Chldren.

The Committee has been asked by various sources to study the nutritional allotments for ADC children. A Sub-committee was appointed by the Chairman to Study this problem. It met, on February 20, for recommendations. Invited to sit in on this meeting were Ad Hoc Committees of the Illinois Chapter, American Academy of Pediatrics; the Chicago Pediatric Society; representatives from the Department of Public Aid; and delegates from the Department of Public Health. Recommendations were made to the Board of Trustees for its March meeting.

Ralph Kunstadter, *Chairman*

Richard E. Dukes	Kenneth S. Nolan
Willard W. Fullerton	Herbert F. Philipsborn, Jr.
Raymond Eveloff	Arthur L. Shafton
Howard R. Hone	Walter G. Steiner
Edward F. Lis	Norman T. Welford
Fred P. Long	Walter M. Whitaker

ENVIRONMENTAL HEALTH COMMITTEE

This is the first report of the Committee on Environmental Health. The Committee, which was formed in August of 1963, has the following responsibilities:

The Committee on Environmental Health is responsible for medicine's interest in the relationship of man to his surroundings, particularly those areas which pertain to the control of transmissable disease; to air, water and soil pollution; to health problems related to population growth; and to urbanization and technological developments bearing on the ecology of man.

This Committee's membership consists of a chairman, two members at large, and the chairmen of the following committees: Child Health, Laboratory Evaluation, Narcotics and Hazardous Substances, Occupational Health, and Radiation.

After discussion with the Executive Administrator and the staff director, it was decided to postpone the first formal committee meeting until a specific direct issue or controversial subject arose. The general policy of the committee is to work on problems in the areas described in the above mandate. When the particular issue involved concerns specific areas—such as radiation, occupational health, narcotics, etc.—it is anticipated that the particular committee assigned to that area would assume the study. The Environmental Health Committee would enter the discussion only at the invitation of the special committee.

Dr. Robert Maganini represented the Committee at the Third Annual Committee Workshop of the State Medical Society. The chairman of the Committee was involved in correspondence with the State Health Department regarding a survey of current and proposed State legislation of interest or concern to the practicing physicians and members of the State Medical Society in the area of environmental health. He initiated other direct correspondence with the newly-created Illinois Air Pollution Control Board through one of its members, who also happens to be a member of the State Medical Society. This correspondence was in regard to the possibility of a regional approach to metropolitan air pollution problems in and around Chicago, and also to the particular role that the ISMS Committee on Environmental Health would play in such a study. This correspondence is still active.

On January 10, the Committee chairman also attended a meeting which was called by the State Director of the Department of Public Health at the suggestion of Governor Kerner to discuss the possibility of locating the National Environmental Health Center in Illinois.

Plans have been made for the chairman and perhaps other members of the Committee to attend the AMA Congress on Environmental Health Problems scheduled for May 1 and 2, 1964, in Chicago. In connection with this, a two page questionnaire was submitted to the AMA at their request.

Edward Press, *Chairman*	James B. Hartney
Robert J. Maganini	Ross A. Schlich
Franklin D. Yoder	Edward C. Holmblad
Ralph Kunstadter	Howard C. Burkhead

EYE HEALTH COMMITTEE

Report not available at publication time. Please check handbook index for late reports.

MATERNAL WELFARE COMMITTEE

The Maternal Welfare Committee has held three meetings in the past year. It is anticipated that a fourth meeting will be held prior to the annual meeting of the State Medical Society.

At these conferences the usual format of discussion of the maternal death protocols for the downstate Illinois and Cook County Hospital has been followed. In an attempt to create a body of facts which will be comparable to data elucidated by other state Maternal Welfare Committees, your committee will, commencing with the 1964 death studies, attempt to code all of these deaths according to the classifications outlined in *A Guide for Maternal Death Studies* as published by the AMA.

Close liaison between the Illinois Department of Public Health, the Division of Hospitals and the State Maternal Welfare Committee has been a source of continuing satisfaction to all parties concerned. During the past year the opinion of the Maternal Welfare Committee has been sought relative to such diverse subjects as proper precautions in setting up a policy regarding the admission of clean gynecological patients to the obstetrical floor

and a proper attitude towards visitors in the labor and delivery room suite.

A matter of continuing interest to your committee has been the lowering of maternal mortality throughout the state of Illinois. Your chairman regrets to report that maternal mortality has been maintained at a relative plateau for the past three years. While the state rate of less than three deaths per 10,000 live births is a very creditable one, we hope that some measures may be taken to improve this record. In line with these hopes the following proposals have been made by your committee for possible approval and implementation by the Board of Trustees:

(1) It is to be noted that in less than 50 per cent of the cases studied, the recommendations of the committee were requested by those involved in tragic circumstances.

(2) It is of great importance that these studies be carried out under circumstances which elicit the cooperation of the persons involved and in a manner of true scientific inquiry. At no time in its deliberations has your committee failed to recognize that in various areas throughout the state, circumstances exist which still mitigate against optimum management of every parturient.

(3) Your committee recommends that the material elicited as a result of its deliberations be made more widely available. Possible suggestions for implementation of this recommendation are:

(a) The publication in the ISMS *Journal* of interesting and informative articles relative to the problems which exist in this field.

(b) The possibility of presenting a program annually in each of the districts relative to recommendations of your committee for lowering maternal mortality.

(c) Annual meetings of each county medical society to which the district representative to the Maternal Welfare Committee could be invited to present a general summary of the findings and recommendations of your committee as they apply to better maternal care.

(d) An improved program of public information to acquaint prospective parents with the facilities which are not only available, but are necessary to be used if we are to make further significant progress.

The committee is justly proud of its continuing role of cooperation and participation in the Perinatal Mortality Committee under the chairmanship of Dr. Philipsborn.

The dedication of the various committee members is indicated by the consistent record of attendance at the deliberations of the committee and by their participation in such educational enterprises as the annual congress of the Illinois Association of Maternal and Infant Health.

Additionally, your chairman wishes to express his appreciation to the individual members of the committee and to the staff of the ISMS, particularly Mr. Al Boeck, whose efforts have made our deliberations much more convenient and worthwhile. The continued interest and advice of Dr. Fred Falls as emeritus member of the committee, and of Dr. W. C. Scrivner as a representative from the Board of Trustees, have been of great value to us.

Finally, he would be remiss if he failed to note the fine spirit of cooperation which exists between your committee and the Illinois Department of Public Health—particularly with Dr. John Rendok, the consultant in obstetrics for the Department.

It is our hope that the coming year will see significant advances made in both the field of maternal and perinatal mortality.

R. R. Hartman, *Chairman*
F. H. Falls, *Chairman Emeritus*

A. B. Owen	J. B. Waller
W. J. Farley	R. E. Bucher
G. H. Rezek	C. K. Wells
V. B. Adams	B. V. Rife
W. W. Curtis	J. R. O'Donnell

Mila Pierce, *Consultant in Hematology*
Matthew Bulfin, *Representative of the Suburban Cook County Maternal Welfare Committee*
Augusta Webster, *Chief, O.B. Section, Cook County Hospital*

MEDICAL EDUCATION AND HOSPITALS (AMA-ERF)

Report not available at publication time. Please check handbook index for late reports.

COMMITTEE ON MENTAL HEALTH

The First Congress on Mental Health sponsored by the ISMS was held at the Sherman Hotel in October, 1963. The publicity given to this meeting was distributed throughout the State. The Committee has cooperated in planning programs with the State Department of Mental Health.

The members of the Committee attended the 10th Annual Conference of chairmen of Mental Health Committees of State Medical Societies sponsored by the A.M.A. Council on Mental Health. Plans are being initiated to work with the local County Medical Societies so that mental health planning can be implemented at the local community level. The Committee feels that much more is needed to activate the component County Medical Societies of the State in recognizing their responsibilities in bringing improved mental health services to their respective communities. Much effort during the coming year will be devoted to this effort. The Federal Program on mental health is far reaching in community orientation. The committee feels that the I.S.M.S. should participate in the initiation of this program.

Harry Phillips, *Chairman*	Richard J. Graff
Arthur G. Baker	Harry Nesmith
Walter H. Baer	Murray E. Rolens
Louis D. Boshes	Harold M. Visotsky
Irving Frank	Donald Oken

Auxiliary representation: Mrs. Glenn R. Marshall

COMMITTEE ON NURSING

The Nursing Committee is pleased to report to the House of Delegates that the Associate Degree Program in nursing is underway in Illinois. This climaxes a four year effort by the interested professions to provide a new group of nursing candidates to be trained as bedside nurses in their own communities and hopefully to remain as local practitioners.

The Kellogg Foundation has provided a one-half million dollar grant to finance the training of faculty and also to help five schools in Illinois to set up this program.

The problem of the correspondence schools of practical nursing has not waned. Continuing efforts will be made to stop these completely inadequate and misleading operations from preying upon the citizens of Illinois.

The Nursing Committee requests that the House of Delegates approve the addition of a professional nurse as a staff member at ISMS headquarters. This will provide proper liason between the two professions which have the same single purpose—the health of the public in Illinois.

Ted LeBoy, *Chairman*
Angelo P. Creticos
J. O. Firth
W. I. Taylor
Anna A. Marcus
Paul P. Youngberg

COMMITTEE ON NUTRITION

The proposed future activities of the Committee on Nutrition include:

(1) A conference on Nutrition in Medicine, October 9 and 10, 1964, at the Center for Continuing Education, University of Chicago. This conference is jointly sponsored by the Committee on Nutrition of the ISMS, the Chicago Nutrition Committee, and the Illinois Dietetic Association.

(2) On February 27, 1964, the Committee will attend a Conference on Nutrition and the Heart, in Jacksonville, Illinois. This Conference is jointly sponsored by the Committee on Nutrition of the ISMS and the Illinois Heart Association.

(3) Further enlargement and editing of the *Diet Manual* is being prepared by the Division of Hospitals and Chronic Diseases, Department of Public Health. The Committee on Nutrition is cooperating with other interested agencies in the preparation of this book for use in nursing homes, rest homes and hospitals. Dr. James R. Wilson has represented the Committee during the past two years in this work soon to be published.

(4) We are continuing our educational program to have seeds which have been treated with anti-rot or fungicidal chemicals stained with a distinctive color to prevent their being mixed with edible seeds and grains. At this time the hybrid seed corn industry is coloring planting seeds a distinctive red. This program will protect the public against accidental or deliberate poisoning.

(5) Dr. James R. Wilson, member of our Committee, is co-ordinator of the Ad Hoc Water Committee sponsored by Scientific and Educational Foundation of the ISMS. The work of this group enters the nutritional field because water is an essential ingredient of all canned, prepared, or packaged foods. Thus, water supplies on a global basis may enter into our diet in Illinois. Their report to date was carried in the January issue of the Illinois State Medical Journal.

A review of Committee activities during the preceding year include attendance at the Annual Conference of the Committee on Nutrition and the Illinois Nutrition Committee. This meeting was held in Springfield, Illinois. It is, in part, underwritten by the Illinois Department of Public Health. The meeting was held October 5, 1963.

Summary

The Chairman wishes to thank the members of the Committee for their efforts during the past year.

Doctors Frank Norbury, Grace Goldsmith, Julius Kowalski and Mr. Clarence Klassen are to be commended for their work with the Committee. Also the officers of the Chicago Nutrition Association, the Illinois Dietetic Association, the Illinois Nutrition Committee, and the Department of Public Health.

Our long time director of Scientific Activities, Al Boeck, and the lay personnel at the State Medical Society have co-operated fully in the success of last year.

Due to illness, the Chairman has not been too active these past several months. He views with satisfaction the increasing maturity and sophistication in nutrition education, the jointly sponsored meetings of ethically oriented lay nutrition groups and the approval of the officers and members of the State Medical Society of our ever widening endeavors of the past several years.

Paul A. Dailey, *Chairman*
James R. Wilson
J. B. Hall
Warner Newcomb
W. I. Taylor

JOINT PERINATAL MORTALITY COMMITTEE

The Proposed future activities and requests for action by the House of Delegates are listed below.

(1) The Joint Perinatal Committee will continue to code perinatal deaths.

(2) The Joint Perinatal Committee will consider expansion of its Pilot Study to additional counties.

(3) The need for safe and effective methods to make meaningful educational experiences from the coded material will receive further consideration.

(4) We will sponsor another day-long seminar concerned with the newly born.

(5) We will explore the methods of increasing perinatal survival rates.

(6) We propose that the House act to establish a registry of perinatal deaths.

We suggest the following proposed resolution for Perinatal Registry:

WHEREAS, the statistical data on perinatal

mortality has been incomplete, and at times inaccurate; and *WHEREAS*, perinatal care cannot be evaluated with any degree of accuracy without adequate data; and *WHEREAS*, a meaningful interpretation of perinatal mortality cannot be made without standard procedures throughout the State of Illinois; *BE IT RESOLVED* that all maternity hospitals, maternity divisions of general hospitals, and nurseries for the newborn be required to maintain a registry for all perinatal deaths. This registry shall include the following: (a) Cause of death, (b) gestational age, (c) live born or stillborn, (4) single or multiple births, (e) sex, (f) weight, (g) race, (h) appearance (i.e., premature, immature, etc.), (i) presentation, (j) abnormal signs or symptoms, (k) abnormal laboratory studies, (l) type of feedings and when begun, (m) surgical procedure, (n) congenital defects, (o) date of death, (p) age at death, and (q) autopsy findings. *BE IT FURTHER RESOLVED* that a central registry be maintained in strategic areas throughout the State of Illinois to correlate these statistics.

(7) The need for funds will increase as the Committee's activities inevitably accelerate. These activities are now beyond the organizational stage and demand increased time, as well as travel, by the Committee members.

Activities During Preceding Year

A Perinatal Pilot Study Sheet was completed during the past year. It consists of 36 headings concerned both with the mother and her infant. This data sheet is voluntarily completed by the participating hospitals within the eleven counties involved in the Pilot Study. The data sheets are coded and then sent to the Perinatal Mortality Committee. When sufficient data sheets are available, the material is reviewed by an appropriate Subcommittee.

The cooperation of the participating hospitals is increasing. As a consequence, the demands on the Committee have been augmented.

The Committee-sponsored Seminar on Perinatal Mortality held in Carbondale, along with numerous speaking engagements by various members of this Committee, are a part of its planned education effort.

Summary

WHEREAS, the previous year has been one of organization, this year has been one of increasing activity. The tempo of educational efforts and the pace at which perinatal deaths have been reviewed is accelerating. Next year we anticipate expansion and increased activity.

Herbert F. Philipsborn, Jr., *Chairman*
Raymond Eveloff
Walter G. Steiner
Robert R. Hartman
Charles K. Wells
William Curtis
Paul A. Dailey
Leo G. Perucca
Simon Y. Saltman
Donaldson F. Rawlings
John H. Rendok
John A. Taft,
Velma Foresman
Robert H. West

POSTGRADUATE MEDICAL EDUCATION AND SCIENTIFIC SERVICE

The role of the State Medical Society in postgraduate education is difficult to establish. Our observations suggest that both a desire and need for postgraduate education exist in a number of counties throughout the state. Furthermore, that existing facilities and arrangements have, for the most part, achieved their intended purpose.

There is an increasing number of requests for speakers on medical subjects of a more general nature. In light of such requests, the Committee feels that an increase in the honorarium to $50 would encourage—and more adequately compensate—more medical authorities who are qualified to deal with these subjects. For the second consecutive year, the Committee requests such approval from the House of Delegates.

The Committee further recommends that its cumbersome and ill-defined title might well be shortened to "Committee on Continuing Education," which more nearly describes its function.

The strength of the program which resulted from the revision of the Speaker's Bureau Roster in 1962 continued through 1963. Although the number of requests for postgraduate programs was disappointing, the four programs that were held were well received. We hope that more counties or districts will take advantage of the opportunity to sponsor postgraduate programs in 1964.

Our program attracted the attention of Merck, Sharp & Dohme. This organization requested permission to underwrite part of the program with a grant. MSD provided a grant of $3,200 to the Educational and Scientific Foundation of ISMS. Notices of the grant and its terms were sent to all county society secretaries and program chairmen.

The evaluation forms sent in by the program chairmen and speakers are, for the most part, exceptionally complimentary. In a few areas the local arrangements were in need of improvement so a leaflet titled *Rx For A Good Meeting* was prepared to assist program chairmen. Copies were sent to all county society presidents and secretaries.

During the period of March 1, 1963, to February 28, 1964, postgraduate courses were presented in Champaign County, Coles-Cumberland County, Tazewell County and Jackson County. Seventeen speakers were featured, 2,533 programs were printed and distributed, and 3,485 postcards were mailed.

There was a slight increase in the number of counties served by the speakers bureau (25), and also in the number of speakers who went out (65). Counties taking advantage of the Speakers Bureau were Adams (1 speaker), Bureau (8), Champaign (3), Christian (2), Coles-Cumberland (1), DeKalb (3), Fulton (1), Greene (1), Henry (1), Kankakee (1), Knox (4), LaSalle (5), Lee (1), Livingston (1), Madison (1), McDonough (3), McHenry (4), Morgan (1), Cook (3), Peoria (1), Rock Island (3), Stephenson (5), Vermilion (2), Wayne (1), and Whiteside (6). Also, the Southern

Illinois Medical Association requested one speaker, and the Second Trustee District received one.

Some counties still handle their own meetings and do not use the Speakers Bureau; some use the Bureau but pay the speakers themselves. It seems strange that these counties do not avail themselves of this service and prefer to use their own funds for programs they could receive at no cost. They are urged to consider the Bureau in preference to their present system.

Robert J. Freeark, *Chairman*

Hyman J. Zimmerman	Harold Laufman
Leon O. Jacobson	Edwin H. Irons
Louis R. Limarzi	J. Mather Pfeiffenberger
Joseph H. Skom	William M. Lees
Ralph Kunstadter	Hubert L. Allen

COMMITTEE ON RADIATION

The Committee on Radiation of the ISMS wishes to report the action taken by our Committee and the Board of Trustees.

The Radiation Monitoring Act of the State of Illinois requires employers to provide personnel radiation monitoring. A question arose as to whom does this specifically applies. Our Committee, after much discussion, offered the following:

(1) Every operator or handler of a radiation source shall wear a film badge.

(2) Every other person working in the immediate environs of a radiation source should wear a film badge.

This recommendation was approved by the Board of Trustees and forwarded to the Director of the Illinois Department of Public Health for his consideration.

Administrative Procedures and Regulations for Users of Radioactive Isotopes circulated to 300 licensed hospitals in Illinois by the Illinois Department of Public Health outlines basic care and practices in the use of isotopes. It is hoped that through such information better knowledge of proper protective measures will be distributed to personnel working in radiation areas.

The Committee wishes to express its appreciation for the aid given by the Department of Public Health. It is our hope that through the combined efforts of the Department of Public Health, the Board of Trustees, and our Committee better, safer diagnostic and therapeutical radiological procedures will be available to patients.

Howard C. Burkhead	Robert W. Donnelly
Earl E. Barth	Robert S. Landauer
Stephen L. Casper	Harvey White
James A. Crilly	Raymond B. White
Fred H. Decker	

SCIENTIFIC ASSEMBLY

Report not available at publication time. Please check handbook index for late reports.

COMMITTEE TO STUDY THE CONVENTION

The Committee met on October 3, 1963, and February 13, 1964, to consider the Morgan County resolution calling for the establishment of a section on general practice. Several points pertinent to the subject were made:

(1) The Convention is supposed to be oriented to the general practitioner.

(2) The Illinois Academy of General Practice, represented on the Committee by Dr. Robinson, opposes the separation of the general practitioners into a special session as this would contribute to the further fragmentation of the meeting.

(3) The entire subject of sections is in review and major changes in the structure of the meeting are possible. *Therefore, the Committee recommends that no new section be formed at this time.*

Because the success of any meeting depends on providing a program which meets the needs of the members, the Committee is planning to survey all ISMS members to obtain their ideas on a good convention.

Other major problems discussed in considering the convention were member attendance and exhibit sales. These are inter-related with other problems and they all focus attention on the basic structure of the meeting. The format has not been changed appreciably in many years and the Committee, after careful deliberation, *makes the following recommendations* as a means of providing the members with an improved scientific meeting, and in an effort to attract more exhibitors:

(1) That the scientific meeting be limited to three days—Monday, Tuesday and Wednesday.

(2) That the House of Delegates meet on Sunday evening and Tuesday evening, with a third meeting on Wednesday morning if necessary.

(3) That the sections all meet on Monday, either between 8:30 and 12 or 1:30 and 5:00. Exhibit breaks of one hour each morning and afternoon should be made mandatory.

(4) Tuesday and Wednesday should be General Assembly days, with the Camp Memorial Lecture on Wednesday afternoon. All lectures should be limited to a maximum of thirty minutes.

(5) That there be round table luncheons on Tuesday and Wednesday enabling the members to chat informally with the speakers.

(6) The annual banquet be on Wednesday evening.

These recommendations are made as a means of providing a type of meeting that will overcome poor attendance, minimize competing programs, halt the declining number of scientific and technical exhibits and raise the general scientific standard of the Convention.

George F. Lull, *Chairman*	E. Chester Bone
William M. Lees	Norman E. Powers
H. Marchmont-Robinson	Edwin S. Hamilton

COMMITTEE ON TUBERCULOSIS

The Committee recognizes the continuing prob-

lem of tuberculosis in Illinois and the need for adequate tuberculin testing throughout the State. Following the recommendation of the 1963 House of Delegates, the Chairman wrote all county medical society presidents to this effect and urged every physician to perform routine tuberculin testing in his practice. Additional publicity on the subject was obtained by having the *Illinois Medical Journal* reprint *The Sleeping Dragon—TB.*

At the request of the Illinois Tuberculosis Association the Committee reviewed *Proposed Program Standards For A TB Program.* The Committee agreed with the principle of stepped-up programs of case findings, health education and tuberculosis control, but cautioned that any program must be tailored to fit the community in which it is to function.

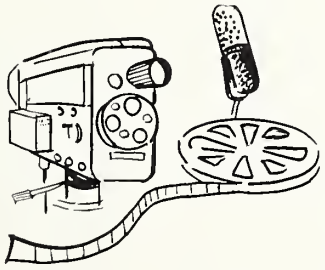
In regard to the administration and interpretation of tuberculin tests by paramedical personnel, the Committee acknowledged that such testing should be done by physicians. However, since this is not always possible, paramedical personnel should be trained to carry out these procedures.

Recognizing the possible value of the hydro spray jet for the administration of tuberculin, the Commitee reserves judgment until it has had further application and evaluation.

Illinois law requires that a physician certify that inmates of nursing homes and homes for the aged be free of communicable diseases—including tuberculosis—before admission. This presents problems because many of these patients are not ambulatory. There is no definite agreement on the value of tuberculin testing in the aged nor the best procedure for x-raying these people. A study being made in DuPage County is expected to provide useful information on this matter.

The Committee believes that newly-diagnosed cases of tuberculosis should start treatment in a hospital, preferably a TB sanatorium. Should an active case be discovered in a general hospital, this hospital should instruct the patient and attendants and institute therapy while awaiting transfer to a sanatorium for evaluation and continued management.

Charles K. Petter, *Chairman*
Otto L. Bettag
William J. Bryan
Clifton F. Hall
George W. Holmes
Charles A. Lang
David F. Loewen
Darrell H. Trumpe
George C. Turner
Raymond H. Runde



COMMITTEES ASSIGNED TO DIVISION OF PUBLIC RELATIONS AND FIELD SERVICES

ADVISORY TO STUDENT AMERICAN MEDICAL ASSOCIATION

Report not available at publication time. Please check handbook index for late reports.

DISASTER MEDICAL CARE COMMITTEE

The committee on Disaster Medical Care enjoyed its busiest and most productive year since its inception three years ago. A great deal of work still lies ahead.

Medical Self Help Training Program

A major project was the telecasting of the Medical Self Help Training course in the form of 16 weekly, half-hour programs on Station WTTW, Channel 11, Chicago, from October 10, 1963, to January 23, 1964. The series was produced in cooperation with the Illinois Department of Public Health, which contributed $10,000 toward its production.

Thanks to an ambitious promotional program spearheaded by the ISMS Woman's Auxiliary, we enrolled more than 10,000 people in the course and were the recipients of some 100 news stories in the Chicago area press. Promotional articles also appeared in the AMA News, Medical Tribune, PR Doctor, and various other publications.

To help them study the techniques taught in the TV lessons, we provided our students with the Family Guide for Emergency Medical Care booklet. At the conclusion of the series, we obtained the cooperation of the ISMS Woman's Auxiliary, Kane County Superintendent of Schools, and the Cook, DuPage, Lake and Will County Health Departments in the testing of these students.

Though only 1,000 students of the original 10,000 registrants actually completed the course, WTTW officials claim it was viewed by over 500,000 persons each week. Though the series lacked the polish of a commercial program done with professionals, it seems to have accomplished its two-fold purpose:

(1) it did an effective job of teaching emergency medical care, and (2) it served to promote the "live" MSHT courses taught in and around Chicago. The Chicago Board of Health, for instance, reported a tremendous increase in its MSHT enrollments as the result of our series.

In addition, we must not overlook the public relations value of the series. We feel it did much to enhance the image of the Illinois physician. For this, we express our appreciation to the Public Relations staff for its fine efforts in producing this series.

In order that county societies may share in the success of this series, 16mm films have been made from the video tapes and are available to the societies without charge. In view of the public enthusiasm expressed for the series—and its built-in public relations value—we urge the state society to promote the use of these films to the best of its ability.

Disaster Manual for Hospitals

During the past year, the committee distributed more than 700 copies of its Disaster Manual for Hospitals to county societies and hospitals throughout Illinois. Another 75 copies were sent—upon request—to such organizations as the U.S. Public Health Service, American Hospital Association, and various out-of-state medical societies and hospitals. The manual—patterned after the Memorial Hospital of DuPage County program—received wider distribution than any similar manual in the nation to date.

Its success prompts the committee to produce a revised, hard cover edition for further distribution later this year . . . and a 16mm colored training film on a similar subject.

The training film—to be produced through the Public Relations Division—will demonstrate how effectively a Hospital Disaster program can function when co-ordinated with the Community Disaster program. ISMS and Memorial Hospital launched production of such film in the fall of 1962, but the preliminary film shot for that purpose proved inferior because of its many technical flaws. It is hoped that our new film will serve as a prototype as did the Disaster Manual. Mr. James Slawny of our Public Relations staff is currently exploring production costs. It is quite possible that the funds for its production might be obtained from one of the larger drug companies.

Committee's Resolution to the Governor

The committee is pleased to report that its resolution to the State Civil Defense Agency and the Governor of the State—in which we called for legislation to prevent widespread use of ordinary glass in the construction of public buildings—received nationwide publicity. A vast majority of editorials and comments on the resolution were favorable. The few people who were critical were evidently satisfied when we wrote them explaining our purpose.

As a result of the resolution, Illinois Governor Otto Kerner issued a directive suggesting builders heed our advice and refrain from the use of large expanses of ordinary glass. To our knowledge, this is the first such directive issued in the country. Nothing is accomplished, however, merely by issuing a directive. We must follow up with a program designed to educate the public to the importance of this directive.

Shelter Construction Program Lag

In spite of the crisis over Cuba last fall—at which time there was imminent danger of nuclear war—practically nothing has been done about a tangible shelter construction program. In view of the fact that the only protection against radioactive fallout is a shelter, it is the obligation of the the medical profession—as leaders in preventive medicine—to urge and insist upon a fallout shelter program which is more than a "paper" one.

Civil Defense Emergency Hospital Program

The committee is concerned with the status of the Civil Defense Emergency Hospital program, particularly with respect to the aspects of the training program. Though this program is the first line of medical defense in event of a national disaster, it has been badly neglected due to lack of funds and interest at the various levels in the training of personnel. To resolve this, the committee had been working with the State Civil Defense and State Public Health Department on the development of an intensive CREH training program to familiarize personnel in the utilization of CDEH.

However, recent personnel changes in CDA—which was laying groundwork for the training program—brought a temporary halt to its development. Rather than allow the CDEH training program to die, the committee seeks House of Delegates approval to take the initiative and spearhead its development and implementation in Illinois.

The committee also feels that we should utilize the talents of individuals in other medical and paramedical groups who are willing to contribute their efforts to a Disaster Medical Care program. Utilization of these individuals will be one of the committee's major objectives in future years.

In addition to numerous individual meetings and telephone conferences, a formal committee meeting was held at the Pick Congress Hotel on November 3, 1963, during the AMA Conference on Disaster Care.

Acknowledgements

The work done by the committee has been so extensive it would be impossible to thank everyone. However, we would like to single out—for a special note of thanks—the Public Relations Division, ISMS office staff, Illinois State Nurses Association and WTTW for their help in the difficult production of the Medical Self Help television series.

While we can look back on the past year with a sense of accomplishment, it is important to rec-

ognize that we have only made a small dent in the problem. Much more remains to be done, and the committee is confident that with the continuing support of the Board of Trustees, this will be accomplished.

Max Klinghoffer, *Chairman*	Franklin D. Yoder
Harold C. Lueth	Charles W. Young
Leondard F. Roblee	Edward N. Zinschlag
George Saxl	Mrs. John M. Tindal

ETHICAL RELATIONS COMMITTEE

The function of the Ethical Relations Committee is to review matters involving interpretation of the principles of medical ethics, and also to investigate alleged violations of the Constitution and Bylaws of the State Medical Society or of its component societies. Principally, however, it serves as an appellate body to review those cases of midconduct referred to it by component societies.

The committee had no problems referred to it the past year. Nevertheless, it did conduct a statewide survey of county societies regarding the handling and disposition of their ethical relations cases. It is interesting to note that 60 of the 64 downstate county societies reporting (Chicago Medical Society will be discussed separately) indicated no involvement with ethical relations cases whatsoever.

A total of six disputes involving medical ethics were heard by the other four counties. Of these, two excessive fees. The others involved a misunderstanding, recurrence of ailment, abuse of health insurance fees and unprofessional conduct.

In one case, the physician was advised to reduce his fee. In another case the physician was suspended from membership in his county society. The societies upheld the physicians in two instances. Two other cases are still pending.

The Chicago Medical Society indicated that its Ethical Relations Committee considered 10 cases of misconduct. Two physicians were censored, and another was suspended from membership. The committee found no grounds for disciplinary action in the remaining seven cases.

These statistics, however, do not reflect the entire story. The Chicago Medical Society actually has three other communities screening complaints which might otherwise come before the Ethical Relations Committee. These "screening committees" process as many as 500 inquiries each year. Those cases warranting the attention of the Ethical Relations Committee are referred to it.

Judging from responses to our questionnaire, county societies have ignored our request for uniformity in the naming of committees empowered to handle medical ethics problems. In our 1963 annual report we suggested they adopt the name "Ethical Relations Committee" for committees working in that area. Unfortunately, only four per cent of the 65 counties responding have followed our suggestion. Twenty-four per cent of the county societies refer unethical relations cases to their grievance committees; ten per cent refer them to their boards of censors. About 50 per cent do not have any committee at all established for this purpose.

Charles Allison, *Chairman*

V. B. Adams	Warren W. Young

FIFTY YEAR CLUB

A group of 70 Illinois physicians—one of the largest in history—was admitted to the ISMS Fifty Year Club in 1963, bringing the organization's membership to 496.

Among the initiates were 49 members of the Chicago Medical Society who, according to tradition, received their Fifty Year certificates and pins at the club's 1963 luncheon meeting in Chicago. Downstate physicians received theirs at various meetings of their county societies throughout the year.

As usual, the organization's annual luncheon—held in conjunction with the society's 1963 annual convention in May—was the highlight of the year as evidenced by the 162 members and guests who attended. Feature stories and photographs of the event were published in more than 100 Illinois newspapers.

The 1964 luncheon meeting is scheduled for Tuesday, May 19, in the ballroom of the Sherman House. Dr. George F. Lull will preside in the absence of the chairman, Dr. Morris Fishbein, who will be out of the country. The occasion will be used to introduce a new Fifty Year Club membership certificate, designed by our Public Relations Division.

Initiation figures this year will be down considerably, as only 49 physicians—including 33 from the Chicago Medical Society—are eligible for admission in 1964.

Morris Fishbein, *Chairman*	G. C. Otrich
George F. Lull	Walter Theobald

COMMITTEE ON GRIEVANCES

All but three of the 400 reported complaints against ISMS physicians the past year were settled on the local level by county medical society grievance committees. Two were settled by district grivance committees, while one reached the level of the state medical society.

In that one case, the State Society Grievance Committee upheld the findings of the Seventh District Grievance Committee. Members of this district committee are to be commended for the excellent manner in which they handled the entire matter.

A survey of the activities of Illinois county medical societies produced 64 responses to our questionnaire. Of the 64 reporting, 45 indicated that no complaints had been registered with them during the past year. Only five counties, including Cook, reported more than two complaints.

The following is a tabulation of the questionnaires returned.

Chicago Medical Society*

Cases Completed in 1963	357
Cases Pending	42

Doctor's fees justified	113	68 per cent
Fees not justified—reduced, cancelled or refunded, per recommendation of committee	54	32 per cent
Complaints from obviously psychotic people	33	9 per cent
Doctors reprimanded by committee and/or refused to reduce bill, per recommendation	18	5 per cent
Unjustified criticism of doctors concerning treatment, diagnosis and/or general misunderstandings	78	22 per cent
Miscellaneous—no definite action taken, but letter written to complainants, re: doctors who are not members of society and not cooperating with the committee; complaints later cancelled; M.D.'s negligent in not filling out or furnishing proper medical reports for insurance purposes; complaints received but no doctor's name mentioned, etc.	61	17 per cent
Complaints justified	72	20 per cent
Complaints unjustified	285	80 per cent
Number of doctors referred by committee to the Council for disciplinary action	3	
Complaints referred to Committee to Consider and Investigate Informal Charges of Unethical Conduct	3	
Complainants called in before Grievance Committee	15	
Doctors called in before Grievance Committee	19	

*From report in Chicago Medicine, February 8, 1964

Downstate Counties

Number of counties reporting	63
No complaints	45
One complaint	6
Two complaints	3
Four complaints	2
Six complaints	1
Seven complaints	1
Eight complaints	1
Number of complaints	41
Complaints of Excessive fees**	22
Complaints regarding service**	18
Other reasons	8
Settlements	
through explanation	22
through reduction in fees	11
through other means	9
Pending	4
Physicians upheld	18
Physicians censured or referred to county ethical relations committee	5

**Some complaints involved both fees and service.

An analysis of the survey reveals that the majority of complaints concern fees, not the services of the physicians. This underscores the continuing need to educate both the public and the profession on the advisability of discussing fees prior to the rendering of service. Proof of this is found in the fact that nearly twice as many complaints were settled through a satisfactory explanation of fees, rather than in a reduction thereof.

As has often been stated, the best method of handling grievances is to stop them before they occur.

Arkell M. Vaughn, *Chairman* — Charles E. Fildes
A. K. Baldwin — Victor V. Rockey
Percy E. Hopkins — J. E. Wheeler

ADVISORY COMMITTEE TO THE MEDICAL ASSISTANTS ASSOCIATION

The primary function of this committee is to attend the executive and general meetings of the Illinois Chapter of the Medical Assistants Association and to provide medical advice upon request.

Committee members have dutifully carried out this function over the past year, taking an active part in a number of association meetings, including its 1964 annual convention held last April in Chicago. Most of the problems on which the committee's advice was sought were of the procedural and organizational nature—none requiring a detailed report.

We are pleased to report, however, that the Illinois Chapter of the Medical Assistants Association is doing a commendable job in improving the doctor-employee relationship. In fact—to show its dedication to the medical profession—it authorized a resolution adopted by the American Association of Medical Assistants at its 1963 convention to wit: ". . . the AAMA pledges its support to the American Medical Association on all basic legislative issues and stands ready to offer its services whenever needed."

Fred L. Stuttle, *Chairman* — Harold Swanberg
William G. McCarthy — Carl E. Clark
H. H. Pilliger — Caesar Portes
Maynard Shapiro — Philip G. Thomsen

PHYSICIANS PLACEMENT SERVICE

The Physicians Placement Service—an outgrowth of the Procurement and Assignment Service of World War II—has been in operation for approximately 19 years. Mrs. Robert Swanson has served as secretary since its inception. The responsibilities of this service are two-fold: (1) to assist physicians in finding locations, and (2) to assist communities in finding physicians.

During the past year, the service has been directly responsible for placing 22 physicians, and it has assisted in the placement of 12 others. A total of 31 different communities—which had either depleted their medical services entirely or were in need of a

specialists—were helped by the Physicians Placement Service.

General practitioners were placed in Bensenville (2), Carlinville, Carmi, Chester, Clay City, Columbia, Cypress, Dallas City, DePue, Freeport, Galva, Greenville, Joliet, Lemont, Lewistown, Maywood, Mt. Morris, Martinsville, Percy, Pittsfield, Quincy, St. Elmo, Sheridan and Winfield.

Specialists were situated in: Carlinville, Chicago Heights, Champaign, Downers Grove, Freeport, Quincy, Springfield, University of Illinois and Wilmette.

It is alarming that, though the number of small towns seeking general practitioners continue to mount, available GP's steadily decline. On the other hand—while requests for most specialists are somewhat limited—an increasing number of specialists are seeking placement. Both the GP and the specialist placement problems are common throughout the nation, according to reports read at the Physicians Placement Service Staff Conference held in Portland, Oregon on December 3, 1963.

During the past year 198 general practitioners seeking new locations were listed with the Placement Service. Included in this number were 74 who registered directly or who were referred by the Placement Service of the American Medical Association since the last annual report, and 124 who were carry-overs at their own request from previous years. Of the total referred to above, 68 were removed during the year after they found satisfactory locations in Illinois and elsewhere.

In the same period, 727 specialists were included on our mailing list. Of these, 278 registered directly during the year or were referred by the AMA, and 449 were retained on the mailing list at their own request from previous years. During the same period 267 specialists were removed after they found satisfactory locations or neglected to reply to our follow-up letters.

At the present time 183 openings for general practitioners are listed, including 63 that were listed for the first time since the last annual report. During the same period 27 opportunities for general practitioners were removed for various reasons.

Approximately 139 openings for specialists are listed with the Placement Service at the present time. Since the last report, 14 openings have been removed after we were advised that they had been either filled or cancelled for various reasons.

The Division of Public Relations recently published an attractive brochure explaining the services provided by the Physicians Placement Service. This brochure will be sent to all new members of the society and to physicians who register with the Placement Service. Copies will also be sent to Illinois hospitals and medical schools having internship or residency programs for pacement on their bulletin boards.

Beginning October, 1963, the *Illinois Medical Journal* has devoted at least one full page of each issue to descriptions of rural Illinois communities listed with the Placement Service. It is too early to evaluate the result of this added publicity, but the staff would be interested in opinions from delegates who may have noticed it.

Another innovation since the last annual report has been the field services of Harold Widmer, a representative of our Springfield office. Mr. Widmer has visited several of the communities listed with the Placement Service and has furnished the secretary with very helpful information. He plans to continue this service in connection with his regular field trips.

We continue to cooperate with the Sears-Roebuck Foundation in publicizing its program to Our Placement Service mailing list and with the Illinois Agricultural Association in including the student recipients of loans from the joint fund of that Association and our Society in our mailings of towns under 10,000 population needing additional general practitioners. We also keep the Illinois Academy of General Practice advised of openings, at the request of its secretary.

According to the American Medical Association, only one state medical society is without a Physicians Placement Service at this time, as compared to three a year ago. California has an outstanding Placement Service with two staff persons devoting their full time service to its functions with a $16,000 a year budget.

COMMITTEE ON PUBLIC SAFETY

The activities now in progress for this committee are:

(1) Development of a compendium on First Aid and transportation of injured for ambulance drivers, morticians, small-town police, and sheriffs' personnel;

(2) Distribution of a medical guide for physicians in determining fitness to drive motor vehicles;

(3) A First Aid and disaster check-list for the home;

(4) A statewide research project, in cooperation with the Illinois Department of Public Health, of obtaining and correlating data concerning fatalities (drivers, as well as pedestrians) and blood alcohol levels. Also, continuation of a detailed analysis of vehicular crashes under the sponsorship of the Cornell University Accident Crash Injury Research (ACIR) Project.

(5) Production of a weekly series of 5 to 10 minute television films on Medicine-Out-of-Doors for distribution to Illinois television stations as public service programs.

The Committee on Public Safety desires specific endorsement from the House of Delegates for these continuing projects or rejection, modification, or substitution of others for them. We welcome any topics suggested by the House of Delegates—realizing that the field of public safety is a broad one—but, of necessity, the committee must confine itself to specific areas for maximum performance.

Projects Achieved in 1963-64

For the year 1963-64, several significant projects were achieved. Foremost—nationally—was the resolution on pesticides which was approved by the Illinois House of Delegates and espoused by the Illinois delegation at the American Medical Association Convention in June of 1963. Ultimately, this resolution was passed to the Board of Trustees of the AMA for study and implementation. As a result of this action, it is now AMA policy that the area of pesticides and toxicants will be included under the activities of the Committee on Adverse Reactions of the Council on Drugs and untoward reactions shall be reported by physicians to their respective Departments of Health or directly to the AMA. Heretofore, only drug reactions were so reported, but under a newly-created panel, household, economic and agricultural chemicals are included. Further, a panel of experts in toxicology will keep this field of substances under continual review.

Some of the other activities in which the Committee engaged were the endorsement, in principle, of the AMA's Emergency Identification Program, and publication in the Illinois Medical Journal of a list of sources where such emblematic material is obtainable. The committee endorsed the driver education program in high school curricula, and several members participated in the President's Committee for Driver Safety Conference held in Urbana on December 10-11, 1963.

"White Paper" on Driving Legislation

A good part of the committee's time was expended in drawing up a "White Paper" on the failure for passage of driver legislation by the 1963 legislature. The document is intended for informational purposes for the officers and Board of Trustees since there were obvious indications that the Illinois State Medical Society might be made the scapegoat for the failure of passage of any worthwhile driver legislation. The committee felt that the officers and trustees should have the entire background to the series of meetings which extended over 18 months with personnel from the Secretary of State's office and which involved representation from the Chicago Neurological Society, the Committee on Trauma of the American College of Surgeons, and the Governor's Official Traffic Safety Coordinating Committee. In addition, the Committee had reviewed Statutes from many other states, as well as laws of other countries, in order to glean as much information as possible which could be applicable in Illinois.

Bill 966—the State Society's Bill on driver legislation—had undergone *nine* revisions in consultation with all interested parties and was to be the united effort on driver legislation representing the executive branch of state government, the Illinois State Medical Society, the Illinois Department of Public Health and the office of the Secretary of State.

At the last moment, and by a surprise political maneuver, the Secretary of State introduced Bill 901 which embodied those elements which the medical profession had found to be most objectionable. Their bill called for the reporting of specific medical conditions in broad categories under State Statutes and carried penalties for the physicians who failed to report them. It would be virtually impossible under this law to be honest with any private patient whom the physician examined who also happened to be an auto driver. In all other aspects, the two bills were almost identical.

Our objection, along with the Legislative Committee of the Illinois State Medical Society, was that these limitations on specific medical criteria would be in the State Statutes and could only be revised or changed at two-year intervals, and then only at the pleasure of the legislature and the Governor. If we are to have freedom in diagnosing and treating patients and dealing with an immediate potentially dangerous situation, the medical profession must be permitted to move quickly, through the State Department of Public Health whose personnel are physicians with full knowledge of comparable problems.

The alternative—if Bill 901 were passed—would be to wait, hat in hand, for the pleasure of a group of lay persons (the state legislature) to listen to our pleadings for changes in the Statutes concerning, for example, a definition of psychoneurotic states, dosages of drugs, etc.

The position of this committee is that standards and criteria concerning physical and/or mental limitations are to be governed by Rules and Regulations in the Illinois Department of Public Health. As experience accumulates, these could be altered and likewise—if a condition demanded immediate attention—it could be handled expeditiously through that department rather than the State Legislature.

Reprints of Writings by Committee Members

Reprints of writings by some of the committee members have been used by the National Safety Council. *Hearts of Hunters* was circulated nationally in the latter organization's newsletter prior to the hunting season of 1963. The Illinois Association for the Prevention of Blindness has circulated several safety reprints of this committee concerning eye care and prevention of accidents as relate to the eyes. *Stars and Stripes* in Europe and the Far East reproduced several of these articles for the armed forces.

The United States Public Health Service has used a number of the committee's articles for informational purposes to its field officers throughout the country. A number of state and Canadian provincial conservation agencies reprint the committee's material regularly in their respective publications.

Acknowledgements

This committee has enjoyed excellent working relations with personnel of the American Medical Association having kindred interests, the National

Safety Council, and the Illinois Department of Public Health.

Finally, the Committee expresses its sincere gratitude to James R. Slawny and William E. Anderson of the Administrative staff for unusual diligence and extraordinary efforts in assisting this committee throughout the year. Without their help, our achievements would have been niggardly.

Julius M. Kowalski, *Chairman*

James P. Campbell	Frank W. Newell
James J. Callahan	Walter Plassman
Edward DuVivier	Edward Press
George H. Irwin	Norman J. Rose
Edwin A. Lee	Franklin D. Yoder

MEDICINE-RELIGION COMMITTEE

Medical leaders have long recognized the fact that man cannot be separated into parts in the care and treatment of illness. Man, as a whole being, is affected by spiritual, mental, and psychological as well as physical factors.

For these reasons ISMS least year established a Committee on Medicine and Religion. The functions of this Committee are based on the outlines established by the newly-formed Department of Medicine and Religion of the AMA.

Because the medical-religious needs of patients are contingent and continually changing, the primary objective of our new committee is to establish county committees on Medicine and Religion. The major function of each such committee would be to encourage and arrange frequent, small-group meetings between physicians and members of the clergy. The state committee will also serve as liaison between the county committees and the AMA Department of Religion and Medicine. In addition, it will offer guidelines for establishing and continuing operation of the county committees.

Following the initial meeting on November 24, 1963, the committee began patterning a program designed to accomplish these three major objectives:

(1) *Reveal the need* for establishing a closer understanding and relationship between the clergy and the physician for the ultimate benefit of the patient.

(2) *Establish* basic rules of conduct to act as broad guidelines for both physicians and clergy in best serving the spiritual needs of the patient.

(3) *Encourage* physicians and clergymen to work together as a "Health Team" in serving the total needs of the individual patient.

To date, this program is being implemented with the development of the following materials:

(1) *A Film Strip.* This film will dramatically utilize a shock technique of true case histories showing how a *lack* of understanding between physicians and clergymen can work to undermine the health and progress of the patient. The committee feels that this shock approach will most effectively reveal the need for close co-operation and active participation by the clergymen and the physician.

A supply of the film strips will be made available to every county committee in the state for use as the "opener" to special physician-clergy meetings.

(2) *A handbook.* This publication will offer practical guidelines of conduct for both doctors and clergy in the best way to serve the spiritual needs of the patient. The proposed title of this book is "A Short Course in Clinical Theology." It will include a brief description of the major religious faiths; practical protocol for clergymen visiting a patient in the hospital or exposed to other clinical situations; religious attitudes toward certain kinds of medical treatment, etc.

These booklets will be distributed as "handouts" at the county meetings of physicians and clergy.

In developing these materials, the committee and staff have been privileged to consult with several outstanding experts in the field of medicine and religion, among them: The Rev. Granger Westberg, D.D., Director of the Department of Medicine and Religion at the University of Chicago; Father Francis L. Filas, S.J., Director of the Department of Theology at Loyola University in Chicago; and the Rev. Meredith Thomas, of the First Baptist Church of Mattoon, Illinois.

In addition, Mr. Arne Larson, Assistant Director of the AMA Department of Medicine and Religion, has offered his counsel on innumerable occasions and has helped to publicize the activities of this committee with a recent appearance on "Medical Interview," an ISMS radio show heard over 27 stations throughout the state.

The committee expresses its appreciation to these distinguished authorities, without whose guidance the current program could not have been formulated.

To further expedite completion of the committee's new program, a staff member has attended the recent Medicine-Religion Program held in conjunction with the Work Week of Health in Madison, Wisconsin, and has had a detailed discussion with members of the Department of Medicine and Religion at the University of Chicago.

The most recent activity of the committee will take place in conjunction with the society's Annual Meeting on Tuesday evening, May 19, when it will co-operate in a medicine-religion program held by the Illinois Guild of Catholic Physicians. All ISMS members are cordially invited to attend this meeting.

Although it is still too early to judge the effectiveness of these efforts, the committee is confident that it will create a closer physician-clergy relationship which will reflect in more effective total treatment for patients throughout the state.

Joseph R. Mallory, *Chairman*	Hilliard M. Shair
Charles W. Pfister	J. Ernest Breed
Paul S. Rhoads	Mrs. John Koenig

RURAL HEALTH AND STUDENT LOAN FUND

The major activity of this committee continues to be concerned with attracting physicians to the

smaller communities via our Medical Student Loan Fund program.

Despite an occasional problem of contract violation, we feel that objectives of this program continue to be realized. More than 50 physicians—graduates of this program—are in active practice throughout the state. Increased publicity has made more persons aware of the fact that such a program exists.

On January 28, 1964, the committee met with members of the Illinois Agricultural Association and the University of Illinois Medical School. This group selected 10 students from a group of 35 applicants to participate in the program starting in the fall of 1964.

Every year the number of applicants increases. This necessitates an increasing expenditure of time in participant selection. Our increase of applicants reflects the 15 per cent increase in applications to the University of Illinois Medical School.

Since this results in a greater number of rejections by the University, an increasing number of our applicants are interested primarily in recommendation for admission. Fewer are interested in obtaining loans. Since recommendation for admission is one function of this Board, it is unlikely that we will want for applicants in the future—despite the emergence of many new loan fund sources.

In November, 1963, the committee held a dinner meeting with the participating University of Illinois students and their wives. Speakers were Dean Bennett, University of Illinois Medical School, and Dr. Stanley Nord, President of the Illinois Academy of General Practice. Such meetings stimulate the students' interest in their future field of family practice, and will help them to continue to identify with the Student Loan Fund program.

At this meeting, the committee discussed the possibility of allowing participants an additional year of post graduate training following graduation—either a two-year internship or a one-year internship and a one year residency. It was decided that deviation from this policy should be allowed only if the student wishes to engage in a two-year general practice residency following internship. Committee approval on an individual basis would be necessary.

Upon invitation from the American Medical Association, we presented a report of our Student Loan Fund Program at the AMA National Conference on Rural Health held March 6-7, 1964, in Columbus, Ohio.

The Committee also co-operated with other rural health agencies within the state, particularly the Extension Service of the University of Illinois and the Health Improvement Association. We have tried to be of assistance in community programming whenever possible and hope to increase this area of activity in the near future.

The committee also takes this opportunity to welcome a new member, Dr. Jacob Reisch, and recognize the efforts of a retiring member, Dr. Ed Hamilton, who gave unstintingly of his time and counsel since the inception of this program in 1947. Dr. Hamilton has been a major factor in its success.

Jack L. Gibbs, *Chairman*
Thomas Bunting Jacob Reisch

PUBLIC RELATIONS COMMITTEE

During the past year, the Public Relations Committee concentrated its efforts in three major areas: expanding its radio, television and newspaper projects; planning additional areas of assistance to county medical societies; and improving the public image of the physician.

The expansion of radio and television services was undoubtedly the most successful project, as the society rolled up a record total of 110 public service broadcasting hours in 1963 on its various programs and personal appearances.

To assist county medical societies, the committee produced and distributed instruction booklets entitled "How to Establish a County Medical Society Speakers Bureau"; promotional kits for Community Health Week; and Medical Self Help Training films for local and television use.

The Committee also drew up a 10-point program for improving and maintaining the physician's image with all segments of the public. The 10 points on which the committee's "image campaign" will be based are:

(1) That the physician's first concern is for the well being of his patients regardless of remuneration;

(2) That he strives to improve his professional skills through continuing education;

(3) That he is morally obliged to keep the public informed on all health matters;

(4) That he is obliged to protect the public from fraudulent and unethical practices;

(5) That he is an active force in determining and planning health services and payment for these services;

(6) That he respects and will fight to protect his right to practice medicine under the free enterprise system;

(7) That he welcome constant and close scrutiny by his colleagues;

(8) That his profession recognizes other professions and wishes to participate with them in humanitarian programs;

(9) That his personal conduct is in keeping with the high moral standards of the society;

(10) That he is a good neighbor, respected citizen and active participant in community affairs.

Details of these and other projects will be spelled out in the following sub-committee reports:

Sub-committee on Member Relations

The major function of this sub-committee is the supervision of the statewide lay speakers bureau. During the past year, our staff handled more than 75 requests for physician speakers before lay groups, with audiences totalling well over 3,000.

The speakers bureau—established about three years ago—now lists some 100 physicians as members and ranks among our most valuable public relations services.

To strengthen the link of communications between the downstate physician and local publics, we urged all county societies to form similar bureaus. To help them, we produced and distributed 8-page instructional booklets entitled "How to Form a County Society Speakers Bureau". The attractive, plastic-covered booklet presented a detailed plan of approach to the formation of a bureau and included form letters of solicitation and appreciation, enlistment and request forms.

Andrew J. Brislen, *Chairman*

Radio and Television Sub-committee

Formation of this sub-committee on February 19, 1964, provides the PR Committee with a specific arm to:

(1) Plan, develop and promote specific programming for all ISMS radio and television presentations.

(2) Regulate and control the quality of radio-TV presentations.

(3) Recommend speakers for the ISMS radio-TV speakers' bureau.

(4) Counsel county medical societies in radio and TV techniques.

Major objective of this sub-committee is to continue the tremendous expansion of radio-TV activity begun in 1963 when ISMS compiled a record 110 hours of public service broadcast time—more than five times the record of any previous year.

In establishing this record, the newly-formed radio-TV speakers' bureau supplied guests for a wide variety of local discussion and interview shows. Among them were: WBBM's *Conference Call* and *Freda Kehm* Show; WAAF's *Weekend with Phil Lind Show* (Moderator Phil Lind featured more medical interviews than any other radio or TV personality, and on February 10 was awarded a plaque by the PR Committee as the "outstanding medical interviewer in Chicago radio"); WJJD's *Let's Talk It Over*; WIND's *Perry Marshall* and *John Dreiske Shows;* WBBM-TV's *Lee Phillips Show, Six O'Cloek Report* and *Seven O'Clock Report Shows;* and WBKB's *Lynn Walker Show.*

In all, 71 ISMS physicians made radio-TV appearances during 1963. In terms of establishing a closer rapport with the public and informing them of practical health matters, the value of these appearances cannot be over emphasized.

In addition to supplying guests for radio-TV shows, the PR Committee created and produced a variety of its own programs.

• *Medical Interview,* five-minute weekly discussions on timely medical topics, pre-taped for distribution to 28 radio stations in Illinois. Currently, the show accounts for more than nine hours of ISMS public service broadcasting per month. Since its inception last May, the show rolled up more than 65 hours of public service broadcasting for the society in 1963 and its continuing to be scheduled by 28 stations in 1964.

• *Today's Health Tip,* 30-second radio spots which explain practical health problems. The show features Dr. George F. Lull, immediate past president of the society. Aired four times daily over station WJJD in Chicago, the feature was head more than 1,000 times in Chicago area homes during 1963.

Today's Health Tip proved so popular that WJJD resumed airing it in March of 1964.

Early in 1964 the Radio-Television Subcommittee launched a major promotion to expand broadcasting coverage of both "Medical Interview" and "Today's Health Tip." Entitled "*When Doctors Speak, the Public Listens*" the promotion offers tapes of "Medical Interview," as well as records and scripts of "Today's Health Tip." The scripts are being made available for use by the station announcer or a local physician, who can tag each message with a station or county medical society credit line for local identification and added local appeal.

• *Medical Self Help Training,* an accredited, 16-week television course which began last October on Station WTTW in Chicago and featured Dr. Max Klinghoffer, Diaster Medical Care Committee chairman. More than 10,000 persons enrolled in the course, while some 500,000 others viewed it weekly.

Public demand for the course became so great that films of the entire series are being made available to county medical societies, industries, schools, and service and business organizations. The entire film series is available at a cost of $1,200 or is available on loan to county medical societies without charge. In addition, video tapes are available on a loan or purchase basis for presentation by local TV stations as a public service or as a sponsored service of the county medical society.

At this writing, a brochure announcing the availability of the film series is being prepared for distribution to schools, industries, county medical societies, TV stations, and business, social and service organizations throughout the state.

"Bonus" exposure on radio and television is still being supplied by two presentations prepared in 1962. The *Safeguard Your Health Series,* one-minute television and radio spots featuring actor Burgess Meredith, is still enjoying wide use and popularity after being distributed to all 18 television and 120 radio stations throughout the state two years ago.

New Programming for 1964

Medically Speaking: Early in 1964 this sub-committee launched its new programming schedule with "Medically Speaking," a half-hour weekly series presented on the new UHF station Channel 26, WCIU. An informal, light approach to common medical problems, this new show features panel discussion and questions and answers from a "live" audience. Dr. W. W. Bauer and Dr. Abraham Galperin are permanent panelists and are joined by a different guest panelist each week.

Since 75,000 Chicago homes already have UHF TV sets—and all sets sold after April 1, 1964 are to be equipped with UHF—we can expect a potential viewing audience of over 125,000 by the end of the year.

One-minute Animated TV Spots: By featuring our new corporate image SYMBOL, "Dr. Sims," these six animated presentations on practical health problems achieve an important two-pronged objective: 1) informing the public; and 2) strengthening the corporate identity of ISMS. The series—which began in March with message on measles vaccination—will be distributed to all 18 television stations in Illinois at bi-monthly intervals, thus providing topics of timely interest throughout 1964.

• *Medical News Beat*: A weekly 5-minute news segment on medical subjects of timely interest and appeal to the public. "Medical News Beat" represents both a unique concept in news programming and one of the most energetic television series ever undertaken by a medical society. Though still in the planning stage at this writing, the show is under serious consideration by Station WNBQ in Chicago. The program—to be written and produced by the PR staff—could conceivably achieve a viewing audience of 40 million persons if televised nationally.

• *Medicine in the Out-of- Doors*: This series will feature Dr. Julius M. Kowalski, Chairman of the Public Safety Committee and noted authority on the outdoors, in a weekly 10-minute feature describing medical problems related to out-of-door living and activity. By demonstrating and explaining common medical problems, and how to manage them until the physician arrives, "Medicine in the Out-Of-Doors represents an effective complement to the Medical Self Help Training Series.

At this writing, a proposal of the show is being drafted for presentation to a potential sponsor.

Radio-TV-Press Awards

To stimulate more radio-TV medical programming—and acknowledge achievements in current medical broadcasting this committee is co-operating with the Media Relations Sub-committee in instituting 1964 Medical Journalism Awards for the state society. The first such awards program ever presented by the society, it will honor outstanding efforts by Illinois radio stations, TV stations and newspapers which have helped to establish a closer understanding and rapport between the public and the medical profession.

Invitations to compete have been sent to every radio and TV station in the state, together with ful instructions and rules for entrants. The winner for each category will receive a citation of merit from the society, and honorary awards will be presented to radio and TV stations who have scheduled the greatest number of medical shows during 1964.

As an added incentive, winning entries will be submitted to the AMA Journalism Competition for 1964, which offers a first place cash prize of $1,000.

The tremendous program planned for 1964 is accepted with pride by this new committee as part of a total and continuing effort to keep the citizens of Illinois better informed on health problems.

Robert E. Heerens — Bertram Moss
Max Klinghoffer — Joseph Skom

Group Liaison Sub-Committee

The principal task of this sub-committee is to coordinate the public service activities of the state society with other lay and professional organizations having a legitimate interest in matters effecting public health.

During the past year, we have co-operated with members of the Association of Professions in the production of seven "Medical Interview" radio programs. Medical Interview—a weekly, ISMS series broadcast over 28 different stations—featured representatives of the Illinois Dental Society (three times); the Illinois Society of Professional Engineers, Illinois Pharmaceutical Association and the Illinois Veterinary Medical Association.

The sub-committee also obtained the co-operation of the Illinois Nurses Association and the Chicago Fire Department in taping the Medical Self Help Training television series . . . and the Lake, DuPage, Will, and Cook County Health Departments in the testing of the MSHT students.

In addition, the sub-committee co-operated with the Woman's Auxiliary in the sales of some 125 reception room pamphlet racks, the proceeds of which went to the state and county medical benevolence funds.

A. E. Steer, *Chairman*

Sub-Committee on Community Relations

The major responsibility of this committee is planning activities to enhance the relationship of the state society and county societies with the local communities in Illinois. One enactment of this responsibility received high commendation last October 20-26 with the first nationwide observance of Community Health Week.

Instituted by this Committee in 1962 as a statewide observance of the excellent medical facilities available in Illinois, Community Health Week was adopted by the American Medical Association last year as an annual, national event.

As the "Founding Father" of this event, Illinois was charged with setting a national example for its observance. Your committee helped to fulfill this responsibility by supplying county medical societies with the following aids:

• *Newspaper mats*—both five column and full page—calling attention to the purpose and objectives of Community Health Week. The ads could be sponsored by the county medical society or it could solicit for sponsorship by a local industry or business organization.

• *Television Films*—All 18 television stations in Illinois were supplied with one-minute public service film spots promoting Community Health Week and urging public participation.

• *Radio Show*—A discussion on Community Health Week was taped on the "Medical Interview" series which was aired on some 28 stations throughout the state during Community Health Week.

• *Church Bulletins*—Offered by AMA and reprinted without charge by the Illinois State Medical Society, these bulletins contained appropriate messages describing the unity of body and soul as a basic and fitting reason for observing the blessings of medical progress. The bulletins were available to the county societies in quantity for distribution to local churches.

In Illinois these materials supplemented the AMA kits sent to all county medical societies outlining proposed projects, press releases, speeches, etc., for promotion in local areas.

These combined efforts were amply rewarded by an enthusiastic response to Community Health Week throughout the state. A number of counties opened the week with a front page news story on some outstanding medical facility or activity in the area. Others instituted polio vaccine programs, while still others featured seminars, science fairs, meeting and debates.

Most county societies enlisted the support of other health and public service organizations, opening the week with service recognition dinners and luncheons honoring individuals and outlining plans for the week. Citizens' committees were formed and many served as "doctors' helpers" during polio and tetanus immunization drives. Many communities offered free physical examinations for all school children and sent follow-up cards to the parents advising of the child's condition.

These actvities are a tribute to the county medical societies and not only helped to establish a record high of public interest in community health facilities, but kept Illinois in the forefront as a national leader of Community Health Week.

Matthew B. Eisele, *Chairman*

Sub-committee on Media Relations

It is the responsibility of this committee to:

(1) Accomplish a better understanding and relationship between news media and the medical profession.

(2) Inform the public by furnishing newspaper articles on various health topics.

(3) Encourage codes of working relationships between the press and the county medical societies.

(4) Foster joint meetings at the local level between the news media and the medical profession.

One of the major activities charged to this subcommittee is the writing and distribution of "Safeguard Your Health," a weekly newspaper column on timely health topics distributed to all of the more than 600 newspapers in Illinois. Currently, more than 200 newspapers publish Safeguard regularly and in full, while almost 300 use it at least occasionally. Based on the total circulation of these newspapers and on nationally accepted reading habits, the weekly potential readership of "Safeguard Your Health" is in excess of 3,000,000.

In keeping with the new campaign to strengthen the identity of the society, the "Dr. Sims" corporate symbol is being incorporated into a new masthead for the "Safeguard" articles. It is believed that the addition of artwork—and association with a physician's name—will increase the readership of the article and serve to strengthen the corporate image of the society.

To utilize the material used in "Safeguard" series, the committee plans to reprint the articles in pamphlet form for use with reception room pamphlet racks. Every three months, physicians requesting the pamphlets will receive a new, updated supply. On these pamphlets—as on the "Safeguard" newspaper mastheads—the "Dr. Sims" symbol will be prominently displayed to strengthen corporate identity.

It is anticipated that this pamphlet program will also encourage physicians to purchase the pamphlet racks currently being sold by the Woman's Auxiliary at a price of one dollar each. The money from these purchases go to the State and County Benevolence Funds.

This subcommittee will also cooperate with the Radio-TV Sub-Committee in the presentation of the society's 1964 Radio-TV-Press awards, as reported in detail (on another page) by our Radio-TV subcommittee. We look forward to this program as an important means of stimulating the publication of more medical news items in Illinois newspapers, and also as a means of acknowledging the fine efforts of the press in helping to establish a closer understanding between the public and medical profession.

Conclusion

The corporate symbol referred to in our Radio-TV and Media Relations Sub-committee reports is part of a proposed two-year campaign designed to strengthen the corporate identity of the society.

The committee feels such campaign is necessary to establish the Illinois State Medical Society as a public service minded organization—apart from the thousands of other professional and health service organizations competing in the same PR market.

One way of accomplishing this is through the establishment and consistent use of the fictitious Dr. SIMS—a play in the initials ISMS—plus the constant use of the society symbol (caduceus inside state outline) on every piece of film, booklet, pamphlet, script or release we distribute.

It is our hope that Dr. SIMS, the initials ISMS and the caduceus-state outline symbol will someday become synonymous with the Illinois State Medical Society in the minds of the public, as well as our members.

Charles J. Weigel, *Chairman*

COMMITTEE ON DRUG MANUAL

The work of the Committee was undertaken to conserve tax dollars used for public aid programs. The individual physicians and the medical profession as a group must be concerned with maintaining the proper balance between adequate medical care for welfare recipients and economical use of public funds. With this principle in mind, the Committee was appointed and assigned the arduous task of developing a Drug Manual for physicians' use when prescribing for recipients of public aid.

The Committee on Drug Manual has worked continuously during the past twelve months to refine the Manual in an effort to reflect actual practice. The Manual was approved by the 1963 House of Delegates and the Committee was directed to continue working with the Department of Public Aid in order to keep the drug list effective and up to date. After continuous refinements and numerous meetings, the Committee completed its recommendations and submitted the list of drugs and the Foreword to the Department of Public Aid, after their being submitted to the State Medical Advisory Committee at its meeting January 11, and the Board of Trustees on January 12, 1964.

The Committee has reported its activities at each meeting of the Medical Advisory Committee to the Department of Public Aid and to the Board of Trustees.

The list of drugs has been arranged in several categories, using non-proprietary names wherever possible. It was neither the task nor the intent of the Committee to show preference for any brand name drug or any particular manufacturer. Therefore, when several manufacturers produce the same item it is listed in the Manual by its non-proprietary name. Final acceptance of the Manual is at the discretion of the Department of Public Aid, at whose request the Manual was prepared. Recommendations of the Committee in the list of drugs it prepared in no way constitute an endorsement of any particular product, nor does omission of any specific pharmaceutical indicate disapproval by the Committee.

In keeping with the 1963 directive of the House of Delegates, the Committee will continue to work with the Illinois Department of Public Aid in an effort to keep the Drug Manual effective and current. The Manual includes a wide variety of items and is thought to list the drugs required in the everyday practice of medicine. It should not be considered as final. Experience will make additions and deletions necessary.

The Committee has brought the Manual to the attention of Society members by publishing a one page article in the Journal entitled, "Drug Manual Prepared for Treating Public Aid Patients."

The Committee recommends that suggestions and comments from the membership be submitted to the Committee for review and presentation to the Department of Public Aid when necessary. The Committee further recommends that physicians cooperate in its use when prescribing for public aid recipients.

James A. Weatherly, *Chairman*
Robert C. Muehrcke
Theodore R. Van Dellen

Consultants: Theodore R. Sherrod, M.D., Ph.D.
Louis Gdalman, R.Ph.

RESOLUTIONS

Resolution #64-1

Introduced by: The Macon County Medical Society August 27, 1964

Subject: *Evaluation of Clinical Laboratories*
Referred to: Reference Committee on Changes in Constitution and Bylaws Joseph R. Mallory, Chairman

WHEREAS the modern practice of medicine requires the use of laboratory procedures to assist in diagnosis of disease and control of treatment, and

WHEREAS the laboratory procedures employed often require complicated and delicate equipment and highly trained and skilled personnel, well versed in their use if the results are to be reliable, and

WHEREAS the lay public has a vital interest in the excellence of the clinical laboratories to which they are referred by their private physicians, and

WHEREAS most practicing physicians have neither the time nor the experience necessary to determine the quality of equipment and skill of personnel in the laboratories to which they refer their patients for studies, and

WHEREAS information as to reliability of the clinical laboratories extent would be of great value to the physicians practicing in these localities, and

WHEREAS the membership of the Illinois State Medical Society includes physicians skilled in all branches of medicine and capable of assessing the work of various medical laboratories, and

WHEREAS the Assembly of the State of Illinois has considered the passage of legislation aimed at evaluating and controlling clinical laboratories in the State, and

WHEREAS it is infinitely preferable that evaluation and regulation of medical facilities should be a function of organized medicine rather than of the State, be it therefore

RESOLVED, That the House of Delegates of the Illinois State Medical Society create a "District Committee on Laboratory Evaluation" (in the By-Laws of the Illinois State Medical Society) whose duty shall be to examine the clinical laboratories in each District to determine those which meet minimum standards of excellence as to supervision, personnel, equipment and other facilities, and publish a list by District of those laboratories so examined and approved.

Resolution #64-2

Introduced by: The Madison County Medical Society

Subject: *Revision of Annual Convention Procedures for the House of Delegates*

Referred to: Reference Committee on Changes in Constitution & Bylaws Joseph R. Mallory, Chairman

WHEREAS the House of Delegates of the Illinois State Medical Society is charged with the responsibility to establish the policy of our Society, and

WHEREAS this vitally important function can be best accomplished by properly informed delegates who represent as much as possible all the members of our medical society, and therefore be it

RESOLVED, That except in very acute and rare emergency situations, all committee reports and all resolutions to be submitted to the annual convention shall be published and in the hands of the delegates and the secretary of each component county medical society no less than six weeks before the Annual Meeting of the House of Delegates, and be it further

RESOLVED, That there be no conflict in the schedule of the Reference Committee meetings while the House of Delegates is in session, to permit every delegate to listen to all the deliberations of each reference committee, and have every opportunity to form a judicious opinion of the problems involved, and be it further

RESOLVED, That a list of counties which were represented and the name of the delegates present at each meeting of the House be incorporated into the published official minutes of the session.

Resolution #64-3

Introduced by: Jackson County Medical Society

Subject: *Malpractice Defense for ISMS Members*

Referred to: Reference Committee on Miscellaneous Business Maurice D. Murfin, Chairman

WHEREAS there has been an increasing number of malpractice suits occurring, many of which are reportedly of a "nuisance type"; and

WHEREAS this legal activity has a potentially adverse effect on the cost of medical care, and in certain instances, a potentially deleterious effect on the care of the patient; and

WHEREAS the Illinois State Medical Society is not known to have any program to rectify this situation; be it therefore

RESOLVED, That:

(1) There be established within the Illinois State Medical Society a fund for the improvement of this situation;

(2) An individual committee to deal with each separate case consisting of qualified doctors and competent legal aid be appointed;

(3) Any defensible suit be offered the maximum opportunity of defense to the highest level;

(4) Any member of the Illinois State Medical Society so threatened with such a suit have access to this service.

Resolution #64-4

Introduced by: The DuPage County Medical Society

Subject: *Rotating Internships*

Referred to: Reference Committee on Publications & Scientific Services Harold C. Lueth, Chairman

WHEREAS there is a professed desire for the encouragement of medical graduates to go into general practice, and

WHEREAS a prime exposure to the advantages of a general practice occurs during the 12 to 24 month period of a rotating internship, and

WHEREAS there is an increase in straight (non-rotating internships) being offered annually, the total now being 32 per cent straight internships in the State of Illinois, and

WHEREAS a license to practice medicine is granted to all who pass the written licensure examination, such a license stating that the physician may now "practice medicine in all its fields;" and

WHEREAS physicians who complete a single field of internship training are thus deemed qualified to practice medicine "in all its fields," therefore

BE IT RESOLVED, That the DuPage County Medical Society recommends that the Medical Practices Act of 1963 which states as necessary for licensing "a course of clinical training of not less than 12 months," be revised to read that "a 12 month rotating internship be pre-requisite for licensure," and

BE IT FURTHER RESOLVED, That the Council on Medical Education of the American Medical Association be apprised of these discrepancies and make proper recommendations and action for their correction.

Resolution #64-5

Introduced by: DuPage County Medical Society
Subject: *Affiliation with the Chambers of Commeree*

Referred to: Reference Committee on Miscellaneous Business Maurice D. Murfin, Chairman

WHEREAS Chambers of Commerce are potentially the strongest single force in existance to perpetuate and refine out free-enterprise system, and

WHEREAS Chambers of Commerce are dedicated to the improvement of the general welfare of our communities, and

WHEREAS Chambers of Commerce depend upon and needs the talents are resources of the businessmen and professional men dedicated to the improvement of the free-enterprise system, be it therefore

RESOLVED, That the DuPage County Medical Society recommend that each district medical society endorse and support the Chamber of Commerce within its respective area, and be it further

RESOLVED, That the DuPage County Medical Society recommend that each physician affiliate himself with his local Chamber of Commerce to work for the accomplishment of mutual objectives, within the framework of medical ethics, and be it further

RESOLVED, That this resolution be presented to the House of Delegates of the Illinois State Medical Society for consideration at the State level.

Resolution #64-6

Introduced by: Franklin County Medical Society
Subject: *Statewide meetings of county advisory committees of the Illinois Department of Public Aid*

Referred to: Referrence Committee on Economics and Insurance Harry Nesmith, Chairman

WHEREAS the Franklin County Medical Society has experienced misunderstandings and administrative problems in the various programs under the supervision of the Illinois Department of Public Aid, and

WHEREAS a general discussion of the federal and state laws governing these programs would be of distinct advantage to the physicians rendering medical care to the recipients, and

WHEREAS although the Illinois State Medical Society participates in these programs only in an advisory capacity, nevertheless the state advisory committee is familiar with the rules and regulations isued by the Department, now therefore be it

RESOLVED, That the Illinois State Medical Society consider one or more annual statewide meetings of all county medical society advisory committees to disseminate current information and to assist the local advisory committee in rendering the best type medical care possible under these matching fund programs for the residents of Illinois.

Resolution #64-7

Introduced by: Williamson County Medical Society
Subject: *Obstetrical Fees Under Public Aid Programs*

Referred to: Reference Committee on Economics and Insurance Harry Nesmith, *Chairman*

WHEREAS it is the opinion of the Williamson County Medical Society that the existing rate for obstetrical care for recipients of assistance under programs administered by the State Department of Public Aid is not in keeping with fees offered by other agencies, and

WHEREAS these fees are also inadequate for the services rendered, and

WHEREAS the state agencies cannot expect physicians to participate under existing conditions, now therefore be it

RESOLVED, That the initial pregnancy examination be listed in the same category as a diagnostic office visit of $5.00 to include history, physical examination and record thereof, and be it further

RESOLVED, That laboratory requirements, such as hematocrit, hemoglobin, urinalysis, etc., be charged at the existing public aid schedule for such services, and be it further

RESOLVED, That participating physicians be paid on a fee per visit basis during a prenatal period, which will aid the physician by compensating for patients which leave his service for any reason prior to delivery, and be it further

RESOLVED, That the delivery fee be raised from $50.00 to $75.00 and listed as a charge or fee for delivery only, and be it further

RESOLVED, That complicated deliveries, (including the application of forceps and other etiological entities) be reviewed and considered for additional payment on an individual basis by the local county advisory committee.

Additional data will be made available to the Reference Committee by the Delegate to the 1964 House of Delegates from Williamson County.

Appendix

SUPPLEMENTARY REPORT OF THE POLICY COMMITTEE

To the 1964 House of Delegates

PRESENTING:

(1) Several sample policy statements from various sources to illustrate the type of material to be included in the proposed Policy Manual.

(2) Extensive list of subjects and the titles of ISMS committees involved in areas where policy might be indicated.

FOR THE PURPOSE OF:

(1) A progress report to the 1964 House of Delegates.

(2) The basis for continued activity of the Policy Committee.

(3) To provide an opportunity for members of the House of Delegates to express themselves, to make suggestions, deletions and additions to the structural basis for the future activity of this committee.

Edward A. Piszczek, M.D., Chairman
John Lester Reichert, M.D.
Fred C. Endres, M.D.

SAMPLE POLICY STATEMENTS

(Similar statements to be developed in areas established by the House, the Board, and the various committees.)

Material to be published as a HANDBOOK for guidance of officers, trustees and members of ISMS. Also to be used by staff at headquarters office in determining areas in which activities have been authorized, etc.

BASIC POLICY: (Care of the indigent)

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and then ONLY in conjuction with the other levels of government, in the above order.

"The determination of medical need should be made by a physician, and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

"The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept."

(AMA House, 11/28/60)

PUBLIC SAFETY:

(Examinations for driver's license)

"The House of Delegates objects to the violation of the physician-patient relationship under any mandatory reporting system when drivers' licenses are involved.

"The House approves permitting physical examinations of any driver whom the Secretary of State has "good and sufficient reason to believe constitutes a hazard on the highway."

"The House stated that no statistics have been made available to show that physical impairments represent an excessive hazard to safe driving. We do know that alcohol and speeding are two of the primary causes of accidents. An alcohol test for drivers should be required. We believe this type of legislation would do more to relieve the death toll on our highways. We disapprove of any type of compulsory reporting of physical impairments to the Secretary of State by physicians" . . .

(ISMS House of Delegates—1963)

RELATIVE VALUE COMMITTEE:

The Relative Value Committee recommends the adoption of a firm policy NOT to establish any co-efficient whatsoever at the state level, either now or in the future.

The Committee recommends a policy sanctioning the distribution of the relative value study to component members of the American Medical Association; to specialty societies and associations; to the American Academy of General Practice and to their component satellites.

The committee recommends a policy which will permit distribution of the relative value study upon request to third-party purveyors of health care services, *subject to individual consideration in each case.*

The committee recommends that a charge be made for all copies of the relative value study distributed to individuals or organizations outside of the membership of the Illinois State Medical Society.

The committee recommends that revisions of the relative value study be effected at appropriate intervals upon recommendation of the committee and approval of the Board of Trustees.

(Suggested policy of the committee)

CONTACT SPORTS: (Child Health Committee)

Schools should not include body-contact sports, particularly tackle football and boxing, for children of school age through the ninth grade. Developmental needs of elementary school children are best met if physical activities are informal and not highly competitive. Children of elementary school age are particularly susceptible to bone and joint injury. Adequate medical supervision of all school programs should be required.

Agenices sponsoring athletic activities outside of school programs should be required to provide for competent medical supervision.

(ISMS House of Delegates, 1958)

MATERNAL WELFARE COMMITTEE:

"The committee comes to the Reference Committee with a specific request that we recommend to the House that permission be granted for the publication of the results of the accumulated experience of this committee. Since the jurisdiction of the reference committee terminates with the completion of this report, and since this accumulated material, like fire, can be not only a useful but also a dangerous implement, we recommend to the House that the Council (Board of Trustees) establish a "screening committee" to which the Maternal Welfare Committee may submit not only a general plan of presentation, but also each individual paper. We are of the opinion that such a screening process will be a protection, not only to the state medical society and its component members, but also to those physicians who compose the Maternal Welfare Committee itself.

(House of Delegates, ISMS, 1955)

The Policy Committee of the Board of Trustees has asked all committees to present to the House of Delegates for consideration, a list of policy statements to be incorporated in the preparation of the policy manual. In order to avoid more than one reference committee considering the policy statements in any one area, this procedure was adjudged the most efficient manner in which to secure House action in all areas. It therefore becomes the responsibility of the reference committee considering the report of the Policy Committee, to review the material in general, make general recommendations to the House, and perhaps to select the subjects in which definite policy should be developed in the future. The Policy Committee will either prepare the statement, or refer the request for the establishment of "policy" to the correct committee involved.

Check over the subjects listed and comment in any area.

E. A. Piszczek, Chairman
John Lester Reichert
Fred C. Endres

SUBJECTS UPON WHICH POLICY MIGHT BE ESTABLISHED COMMITTEES OF ISMS WHICH MIGHT ESTABLISH POLICY . . .

Accidents
- Prevention of
- Standards for automobile operators
- cooperation with other agencies

Aging: Committee on
- Retirement
- periodic examinations
- liaison with governmental agenices
- insurance programs

Alcoholism
- treatment and care of
- tests for—drivers license cases

AMA-ERF
- (handled by Committee on Medical Education)

AMA
- cooperation with
- use of "Principles of Medical Ethics"

Archives, Committee on
- Subcommittee on Medical Museum . . .

Armed Forces
- membership dues for men in service (reserve corps—regular army, navy, etc.
- Doctor Draft Law and deferment of physicians

Assistants—Medical Assistants Association
- approval and cooperation with

Athletic programs
- contact sports—boxing, football, etc.

Barbiturates
- control of

Benevolence Committee
- Committee policies for authorization, payment, etc.

Birth
- Committee on Maternal Welfare
- Abortion
- Birth Control
- Artificial Insemination
- Sterilization
- Birth Certificates and "invasion of privacy"

Blood
- Typing of
- Procurement of
- Cooperation with Blood Banks, etc., Red Cross
- Physician in authority at all blood banks, Red Cross, etc.

Board of Trustees
- Interim authority
- Financial responsibility
- Geographical representation
- Power of Executive Committee, etc.

Cancer Control Committee
- Public Education
- Use of state laboratories
- Cancer Detection centers

Cardiovascular Disease Committee

Child Health Committee
- Infant Mortality
- Children's bureau
- School Health Examinations
- School Health Forms
- Local county and/or city programs
- Health education in the schools
- Immunization (mass) programs
- Contact Sports, etc.

Chronic Illness

Civil Defense
- Medical policy in disaster
- Medical self-help programs

Committee on Committees
- Policy relative to proposed changes

Contract Practice
- Free choice of physician
- Definition of

Coroner—Medical Examiner System
- Post mortem
- Autopsies, etc.

- Crime and Criminals
  - Prison conditions
  - Use of human experimentation
  - pardon for participation
  - Psychiatric services, etc.
- Cults:
  - Association with (voluntary—teaching-lecturing—compulsory—and/or speaking)
  - Osteopaths, Chiropractic, Optometrists, Christian Scientists, etc.
  - Hospital staff for DO's with unlimited license
  - Use of title "Doctor"
- Delegates:
  - Election of:
    - ISMS
    - AMA
  - Terms of office
  - Qualifications
  - Credentials
  - Status after seating
- Disaster Melical Care Committee
- Drugs:
  - Prescription of
  - Public Aid—Drug Formulary
  - Advertising policies
  - Experimental use of
  - Cooperation with pharmaceutical association
  - Public education
  - Vaccine distribution
  - Refill of prescriptions
  - Use of antibiotics
- Dues—membership problems
- Economics—Committee on Medical
- Editor—Illinois Medical Journal
- Education—use of federal funds in
  - Loan funds
  - Uniform standards, etc.
- Emergency services
  - County societies encouraged to provide
  - Listing of physicians participating in
- Employees of ISMS
  - Insurance for
  - Retirement
  - Outside employment
- Environmental Health Committee
- Ethical Relations Committee
  - Rights of county societies
  - Rights of individuals
  - Rights of appeal
- Expert Testimony
  - Remuneration
  - Interprofessional Codes
- Eye Health Committee
- Fee Schedule Committee
- Fees
  - Fee splitting
  - Commissions
  - Payment in Full
- Fifty Year Club Committee
- Fluoridation
- Foods and Nutrition
- Foreign Graduates
  - Membership qualifications
  - Urge county societies to accept ethical . . .
  - Encourage citizenship in all cases . . .
- Grievance Committee
  - Guides for action
- Group practice
  - What is a "clinic"?
- Health insurance
  - Compulsory
  - Voluntary
  - in hospital (medical-surgical)
  - in office
  - under social security
- Hospital Relations Committee
  - Utilization committees
  - Staff appointments
  - Assessment of staff members
  - Construction grants
  - Unionization of Hospital employees
- House of Delegates
  - Publication of minutes
  - Recording of minutes
  - Policy statements
  - Replacement of vacancies on committees, etc.
- Hypnosis
- Illinois Association of Professions
- Illinois Bar Association
- Illinois Medical Journal
  - Papers
  - Format
  - Advertising
- Impartial Medical Testimony (Committee on)
- Income Tax
  - Liberty Amendment
  - IRS requirements
- Indigents
  - Care of
  - Responsibility for care
  - Recipients of Public Assistance
- Insurance forms
  - Use of simplified
- Interns
  - Remuneration of
  - Supply and distribution
- Laboratory Evaluation Committee
  - Registration of laboratories
  - MD in charge of
  - Use of state laboratories
- Legal medicine
  - Code for attorneys and physicians
  - Forensic Medicine
  - Unethical testimony
- Legislation, Committee on
  - Limitations of Society under federal and state law
  - Privileges of Society
  - Privileges of individual
  - Routine to follow in proposing new legislation in Springfield
- Licensure
  - Cooperation with state board
  - Fees
  - Registration of physicians
  - Use of fees
  - Control of reciprocity
  - Cancellation of licenses to practice

Medical Assistants Association—
Advisory Committee to
Medical Education, Committee on
AMA-ERF
Medical Testimony
Meetings
Postgraduate Medical Education
Multiplicity of
Hospital staff (compulsory, etc.)
Membership
Dues—transfers
Responsibility of local county society
Transfers from other states
Mental Health—Committee on
Museum, Medical
(See subcommittee of Committee of Archives)
Narcotics and Hazardous Substances—
Committee on
Nursing, Committee on
Responsibility of physician for acts of nurse
Definition of
practical, graduate, registered, licensed, etc.
Educational standards
Accreditation of schools of
Junior colleges
Correspondence schools of
Federal aid to
Nutrition, Committee on
Occupational Health, Committee on
Officers of ISMS
Speak for ISMS
Use of official stationery
Appearance on Radio or TV
Ophthalmology—See Eye Health Committee
Paramedical Groups
Definition of "allied sciences"
Microbiologists—Psycologists, Podiatrists,
Veterinarians
Physical Examinations
Annual—
For physicians
For patients
Pension Programs—Insurance
Placement Service for Physicians
Poisons
Labeling—sale of, records, treatment centers,
pesticides
Pollution
(Air—Water—etc.)
Poliomyelitis vaccine—
Salk and Sabin—Mass immunization—
distribution of vaccine, etc.
Postgraduate Medical Education, Committee on
Responsibility of Society
Prepayment Plans and Organizations—
Committee on
Professional Liability
See Committee on Insurance
Public Aid—Illinois Department of
Public Health—Illinois Department of
Public Relations—Committee on
Contact with press—radio-TV
Speakers' Bureau
Public Safety Committee
Radiation, Committee on
Cooperation with State Department of
Public Health
Licensing of Laboratories
Registration of radio active material
Availability of X-ray films
Responsibility of MD for technician
Redistrict, ISMS, Committee to
Rehabilitation Services—Committee on
Relative Value Study Committee
Religion and Medicine—Committee on
Research
Animal experimentation
Use of new drugs
Federal funds
ISMS Foundation
Rural Health and Student Loan Fund—
Committee on
Supply of physicians
Ability of physician to earn a living in
community involved
Survey of area
Scientific Assembly
Sale of commercial booths
Expense of scientific exhibits
Ownership" of scientific papers
Use of "grants" on program
Liability involved in "live" clinics
Insurance for
Awards
Social functions—financial responsibility
Other groups participating
Scheduling meetings to avoid conflicts
Invited guests
Section meetings—election of section officers—
new sections—
Publication of papers not guaranteed
Social Security
For physicians
Poll of membership
Medical care under . . .
Voluntary Pension Programs
Student Health Services
(Check Champaign setup)
Student AMA—Advisory Committee to
Tuberculosis, Committee on
Control of migratory workers
x-rays in hospitals
Veterans Medical Care
VA facilities for service-connected disabilities
"Means" test
TB cases and psychiatric cases
Care of dependents
Vision and Blindness—see Eye Health Committee
Vital Statistics
Birth certificates—see under "birth"
confidential—uniform system
Voluntary Health Organizations
Water Pollution—see "pollution"
Woman's Auxiliary
Workmen's Compensation—

REFERENCE COMMITTEES FOR 1964 HOUSE OF DELEGATES

COMMITTEE ON CREDENTIALS

This committee shall meet on Sunday, May 17, 6:00 p.m.; Tuesday, May 19, 6:30 p.m.; and Thursday, May 21, 8:30 a.m.

Noel G. Shaw, *Chairman;* John A. Newkirk, *Co Chairman*

J. A. Petrazio, C. C. Maher, Jr., H. Kenneth Scatliff, Robert R. Mustell.

The following committees will meet on Monday, May 18, 1964, from 9:00 A.M. to 12:00 noon.

REFERENCE COMMITTEE ON CHANGES IN CONSTITUTION AND BYLAWS

In the *Life Room, #108:* This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

Joseph R. Mallory, *Chairman*

Edward K. DuVivier, Charles Allison, George H. Irwin, Arthur W. Fleming, E. J. Lukaszewski.

REFERENCE COMMITTEE ON ADMINISTRATIVE SERVICES

In the *Old Chicago Room #101:* This committee shall consider and submit its recommendations to the House of Delegates on the following reports:

The President, the President Elect, the Vice Presidents, and the Secretary-Treasurer.

The report also includes that of the Secretaries' Conference, Trustees of the 11 Trustee Districts, the Trustee at Large (The Immediate Past President), the Chairman of the Board, the Policy Committee, the Speaker of the House, the Vice Speaker of the House, the Executive Administrator, and the ISMS Delegation to the AMA.

Harold A. Sofield, *Chairman*

Francis W. Young, Anna Marcus, John H. Steinkamp, Frank A. Christensen, R. Kent Swedlund.

REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC AFFAIRS

In *The French Room, #107:* This committee shall consider and submit its recommendations to the House of Delegates on the reports of:

Committee on Archives, Medical Museum, Bar Association, Benevolence Committee, Dept. of Registration and Education, Impartial Medical Testimony, Laboratory Evaluation, Legislation, Medico-Legal Committee, Medical Testimony, Narcotics and Hazardous Substances, Occupational Health, and Public Affairs.

I. E. Bartlett, *Chairman*

F. A. Munsey, L. T. Fruin, Casper Epstein, William Hutchison, Joseph R. DeCaro

REFERENCE COMMITTEE ON ECONOMICS AND INSURANCE

In *The Orchid Room, #106:* This committee shall consider and submit its recommendations to the House of Delegates on the reports of:

Advisory Committee, Department of Public Aid, Committee on Drug Formulary, Committee on Aging, Blue Cross-Blue Shield, Committee on Fee Schedules (Federal Medical Services), Hospital Relations Committee, Medical Economics Committee, Prepayment Plans and Organizations, Rehabilitation Services, Relative Value Committee.

G. L. Seitzinger, *Chairman*

C. Elliott Bell, Paul A. Dailey, Clifton L. Reeder, Allison L. Burdick, Sr., Eugene M. Narsette.

REFERENCE COMMITTEE ON PUBLICATIONS SCIENTIFIC SERVICES

In *The Holiday Room, #105:* This committee shall consider and submit its recommendations to the House of Delegates on the reports of:

Illinois Medical Journal—Editor, Editorial Board, Journal Committee, Educational and Scientific Foundation, Cancer Control, Cardiovascular Disease, Child Health, Environmental Health, Eye Health, Maternal Welfare, Medical Education (AMA-ERF), Mental Health, Nursing, Nutrition, Perinatal Mortality, Postgraduate Medical Education and Scientific Service, Radiation Committee, Scientific Assembly, Study Annual Convention, and Tuberculosis.

Harold C. Lueth, *Chairman*

L. F. Mammoser, N. J. Kupferberg, Paul A. Van Pernis, T. P. deGraffenried, Richard Cooper.

REFERENCE COMMITTEE ON PUBLIC RELATIONS

In *The Time Room, #110:* This committee shall consider and submit its recommendations to the House of Delegates on the reports of:

Advisory Committee—Student A.M.A., Disaster Medical Care, Ethical Relations, Fifty Year Club, Grievance Committee, Medical Assistants Assn., Public Relations (Physician Placement Service), Public Safety, Religion and Medicine, and Rural Health and Student Loan.

Charles J. Weigel, *Chairman*

George F. Lull, J. D. McCarthy, Carl Greenstein, W. O. McQuiston, Donald Nellins.

REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

In *The Gold Coast Room, #111:* This committee shall consider all business not allocated to any of the enumerated committees, and any new business to come before the House of Delegates for which no other provisions have been made. Assignments will be made to this committee by the Speaker of the House of Delegates. This committee shall consider and submit its recommendations to the House of Delegates on the reports of:

The Association of Professions, The Committee to Study Committees, Liaison, Illinois Pharmaceutical Association, Committee on Quackery, Commttee to Redistrict ISMS, Woman's Auxiliary, and Committee on Membership.

Maurice D. Murfin, *Chairman*

M. Mijanovich, Lawrence J. Rossi, Clair M. Carey, Norman C. Meyer, C. A. Norberg.

The one tranquilizer that

BELONGS IN EVERY PRACTICE

it's versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy.

Outstanding record of safety: Ten years of clinical use among millions of patients throughout the world—plus more than 1500 published reports covering the use of the drug in almost every field of medicine—support your prescriptions for 'Miltown' (meprobamate). This is why it "*belongs in every practice.*"

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress—and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

Side effects: Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1 to 4 doses of the drug.

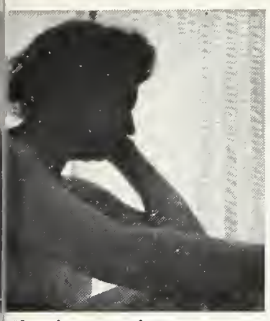
Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians upon request.*

Usual adult dosage: 1 or 2 400 mg. tablets t.i.d.

CM-1114

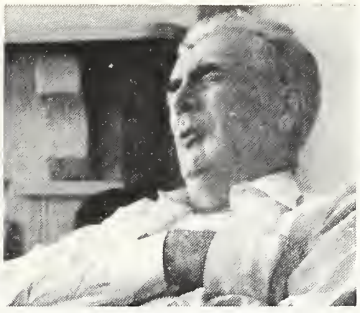
Supplied: 400 mg. scored tablets, 200 mg. coated tablets.



The insomniac



The tense, nervous patient



The heart-disease patient



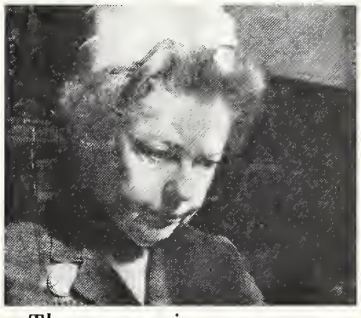
The surgical patient



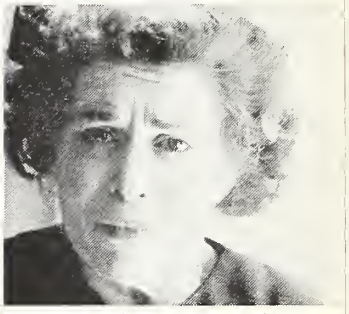
girl with dermatosis



Tension headache



The woman in menopause



Anxious depression



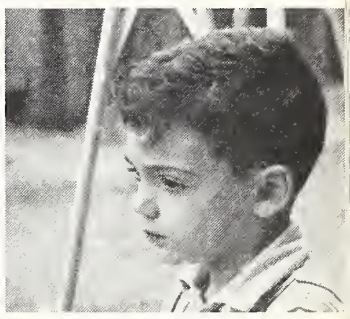
menstrual tension



The agitated senile patient



The alcoholic



The problem child



The G.I. patient

the original brand of meprobamate

Miltown®

WALLACE LABORATORIES
Cranbury, N.J.

ISMS post-convention TRAVEL ADVENTURE TRIP

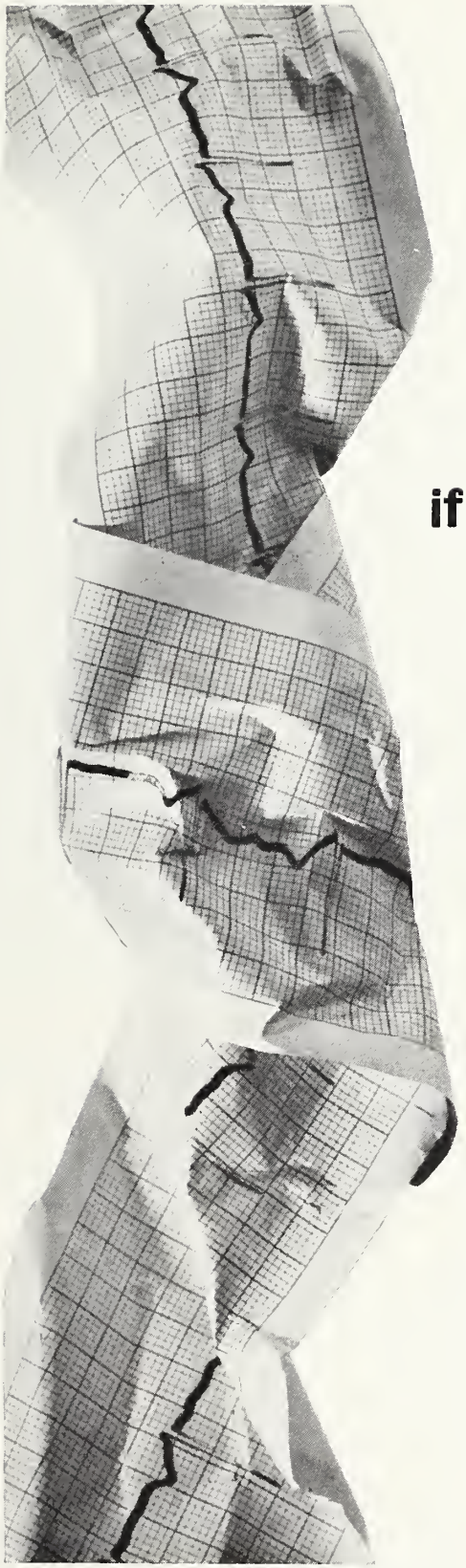


Left to Right: Dr. Francisco Biagi, Professor and Head, Department of Microbiology and Parasitology, School of Medicine, National University of Mexico; Dr. William M. Lees, Chairman of ISMS Committee on Scientific Assembly; Dr. Donato G. Alarcon, Dean, Faculty of Medicine, National University.

The physicians pictured above are planning the post-convention meeting of ISMS in Mexico City. The meeting took place in Dr. Alarcon's office. The program, especially designed for the ISMS group, is to be held in world's largest medical school.

Dr. Lees, after returning from Mexico City where he made the arrangements for the scientific program, said, "Dr. Alarcon and his staff have prepared an excellent program for us. After seeing the medical school and visiting the tour hotel I enthusiastically recommend this program to all. The arrangements were splendidly handled and I'm sure the remaining days of the package tour will be memorable ones for all who go."

(Continued on page 448)



Who do you tell your troubles to, if your electrocardiograph goes on the fritz?

It happens, even to the best of machines.

When it does, a Sanborn owner is in an advantageous position:

The serviceman who answers his call is a Sanborn *employee,* whose only interest is serving *Sanborn* customers.

The serviceman *knows* Sanborn electrocardiographs, what's in them, how they work and why. He can find — and fix — all types of trouble faster.

The serviceman is nearby (42 locations in the United States alone), has complete stocks of repair parts and supplies, modern electronic test equipment and facilities.

When you buy an electrocardiograph, consider the kind of service you'll want should the occasion arise. You can be *sure* of getting it, from Sanborn. Sanborn Company, Medical Division, Waltham, Mass. 02154.

SANBORN
A SUBSIDIARY OF HEWLETT-PACKARD

CHICAGO *Branch Office* 2040 Lincoln Park West, Bittersweet 8-3737
ST. LOUIS *Branch Office* 8615 Manchester Blvd.
Woodland 1-1012 & 1-1013

In Diabetes... wine ...why not?

The ancients recommended it...

"Sixteen hundred years before the discovery of insulin, Aretaeus the Cappadocian... described diabetes and used wine in its treatment . . ."

—S. P. Lucia, "A History of Wine as Therapy," Lippincott, 1963.

So do modern physicians...:

"... wine can be safely and usefully included in the diet of very large segments of the diabetic population."

—"Alcohol and Civilization," McGraw-Hill, 1963.

"... in diabetic patients ... wine probably contributed to the maintenance of reasonably low blood sugar levels."

—Lolli, G.: Quarterly Jl. Studies on Alcohol, Sept. 1963.

The fermented juice of the grape is the oldest medicine known to man. (It is also one of the most delightful.)* It's an unparalleled mild sedative . . . a tranquilizer . . . a tonic . . . of value in convalescence and in old age.

This coupon will bring you an informative booklet—"Uses of Wine in Medical Practice."

WINE ADVISORY BOARD
California State Department of Agriculture
717 Market Street, San Francisco 3, California

Please send free copy of "Uses of Wine in Medical Practice."

Name_____

Address_____

City_____ State_____

☐ Also send recipe booklet.

*P.S.—With your own steak, tonight, try a California burgundy. At bedtime, try a glass of port—a food in liquid form. Check the coupon for a booklet on the gastronomic delights of California wines.

(Continued from page 446)

The trip to Mexico City on Thursday, May 21, is being made an extension of the ISMS Scientific Assembly. There will be a medical meeting Friday morning, May 22. This meeting is being scheduled at the University of Mexico Medical Center and will feature some of Mexico's outstanding physicians. Based on current interpretations of IRS regulations, the program in Mexico should be deductible as a business expense.

A special group rate plan arranged for ISMS members saves more than $100 per couple. Group of 25 or more must travel together to Mexico City, but may return on their own at any time.

The program for the Mexico City sessions appears below.

ISMS EXTENDED SESSION

MEDICAL MEETING AND TOUR

MEXICO CITY, FRIDAY, MAY 22

SCHOOL OF MEDICINE,

NATIONAL UNIVERSITY OF MEXICO

9:00 a.m.—Welcome: Dr. Donato G. Alarcon; Dean of the Faculty of Medicine.

9:05 a.m.—Medical Education in Mexico, Dr. Alarcon.

9:30 a.m.—Treatment of Advanced Cancer of the Lung by Isotope Implants; Dr. Edgardo Zavala, Associate Professor of Medicine.

10:00 a.m.—Hypertension; Dr. Herman Villarreal, Professor of Medicine and Head of the Service of Nephrology at the Heart Institute of Mexico.

10:30 a.m.—Break

11:00—A Comparison of Mycosis As Seen in the U.S. and Mexico; Dr. Antonio Gonzales Ochoa, Professor of Medicine at the School of Medicine and the National Institute of Tropical Diseases.

11:30—Cardiac Decompensation: Newer Methods; Dr. Sodi Pallares, Professor Medicine.

Tours of the Medical School, the world's largest (8,000 students), the National Heart Institute and the Cancer Hospital will be arranged in the afternoon for those interested.



How can JOHNSON'S Baby Lotion help the doctor, the mother and the baby?



The doctor knows the young mother wants to do everything in her power to keep her baby clean and happy and in good health. And more and more evidence points to the fact that the physical expression of her love for her baby is not only a delight to the mother and pleasant for her child, but an essential element in the development of a mature, self-reliant adult * A father as well as a physician, he knows that Johnson's Baby Lotion not only makes changing diapers easier and more pleasant for all concerned, but that the antibacterial effect of its hexachlorophene content (0.5%) persists for days, to protect the baby's delicate skin from rashes and infections. With Johnson's Baby Lotion normal skin functions are unaltered because the protective film is aqueous rather than occlusively oily. These are some of the reasons so many physicians recommend Johnson's Baby Lotion for routine use to protect delicate skin. May we send you samples of this superior antibacterial emollient in the convenient new plastic bottle?

*Donnelly, J.: A.M.A. Arch. Environmental Health 6:697, June, 1963

Johnson & Johnson

New Brunswick, N. J.

© J&J, '64

Technical Exhibitors

Exhibition Hall—Mezzanine Floor
Monday, May 18 to Thursday, May 21
Monday, Tuesday, Wednesday—9-5; Thursday—9-Noon

The Illinois State Medical Society welcomes the participation of the technical exhibitors as an important adjunct to our convention.

Intermissions in the morning and afternoon programs allow time to visit the exhibits. These program interludes will help you keep informed on new drugs, new equipment, and new procedures in the medical field.

The financial support provided by the exhibitors helps considerably in making this convention a success. Every exhibitor here deserves a visit by everyone in attendance.

William M. Lees, M.D.
Chairman, Scientific Assembly

COMPANY	BOOTH NO.
Abbott Laboratories, North Chicago, Illinois	13
Air Shields, Inc., Hatboro, Pennsylvania	41
Americana Corporation, Beverly Hills, California	7
Astra Pharmaceutical Products, Inc., Worcester, Massachusetts	35
Bacon, Whipple & Company, Chicago	56
Berkeley Medical Instruments, Berkeley, California	12
Blue Shield Illinois Medical Service	38
Carnation Company, Los Angeles, California	42
Ciba Pharmaceutical Products, Inc., Summit, New Jersey	58
Coca-Cola Company, Atlanta, Georgia	61
Control-O-Fax Sales, Inc., Subsidiary of Latta's Inc., Waterloo, Iowa	14
Daniels Surgical & Medical Supplies, Chicago	1, 2 & 3
Eder Instrument Company, Chicago	59
Edison Park Laboratories, Elk Grove Village, Ill.	47
Eisele & Company, Nashville, Tennessee	40
Encyclopaedia Britannica, Chicago	31
Forest Hospital, Des Plaines, Illinois	22
Geigy Pharmaceuticals, Yonkers, N.Y.	45
Great Books with the Syntopicon, Chicago	28
Hertz-Rent-All, Chicago	19
Illinois Collectors Association, Inc., Chicago	27
International Pharmaceutical Corporation, Norristown, Pa.	5
Knoll Pharmaceutical Company, Orange, New Jersey	64
Lederle Laboratories, Pearl River, New Jersey	33
Eli Lilly and Company, Indianapolis, Indiana	48
J. B. Lippincott Company, Philadelphia, Pa.	26
P. Lorillard Company, New York, New York	55
Massachusetts Indemnity & Life, Boston Massachusetts	21
Medical Business Consultants, Kenilworth, Illinois	49
Medical Center Books, Chicago	66
The Medical Protective Company, Fort Wayne, Indiana	57
Merck Sharp & Dohme, West Point, Pa.	53
Miller Pharmacal Company, Chicago	30
National Accounts System, Inc., Chicago	37
Nehi-Royal Crown, Corp., Chicago	6
Neutrogene Corporation, Santa Monica, California	23
Pacific Medical Equipment Company, North Hollywood, California	51
Parke, Davis & Company, Detroit, Mich.	44
Parker, Aleshire & Co., Skokie, Ill.	46
Pfizer Laboratories, Brooklyn, New York	50
Professional Life and Casualty, Chicago	62
R. J. Reynolds Tobacco Company, Winston-Salem, North Carolina	68
J. B. Roerig and Company, New York, New York	43
Sandoz Pharmaceuticals, Hanover, N.J.	20
W. B. Saunders Company, Philadelphia, Pennsylvania	4
G. D. Searle & Company, Chicago	60
7-Up Developers Association, Joliet, Illinois	67
Smith, Miller & Patch, Inc., New York, New York	63
E. R. Squibb & Sons, New York, New York	36
Taendler Business Equipment Company, Chicago	32
Trent Pharmaceuticals, Inc., New York, New York	65
Tufts Edgcumbe, Inc. (Piper Aircraft Co.), Lock Haven, Pa.	15
United States Tobacco Company, New York, New York	39
The Upjohn Company, Kalamazoo, Michigan	54
Wallace Laboratories, Cranbury, New Jersey	24-25
Winthrop Laboratories, New York	52
X-Ray Identification Corp., Dearborn, Mich.	16

PULSE
of the ILLINOIS STATE MEDICAL SOCIETY

A Service of the Public Relations Division *April, 1964*

Declare "Spring War" on Polio

A concerted drive to make polio a "disease of the past" is being launched this spring by county medical societies across the state.

Chicago Medical Society's Douglas Park Branch already has enlisted 80,000 persons in their three-phase Sabin program which began March 1 with administration of type 1 vaccine. Two special clinics in the area will administer types 2 and 3 on April 12 and May 24.

DeWitt County Medical Society began its "Sabin on Sunday" program March 8, with administration of type 1 vaccine to more than a third of the residents in the county.

DuPage County Medical Society, which offered the new trivalent vaccine March 22 and will offer it again May 17, is publicizing its polio drive with a dramatic sound film in color for use by groups wishing to learn more about the value of oral polio immunization. The 35 "feeding" stations set up throughout the county can accommodate more than 300,000 persons, making this the largest immunization program ever undertaken in the DuPage County area.

Greene County Medical Society began its trivalent immunization program March 14 in cooperation with the local pharmacists in the area.

Macon County Medical Society has set April 5 and June 7 as the dates for its mass inoculation program, which will be able to accommodate 80,000 of the 120,000 residents in the county.

Macoupin County Medical Society will have the help of nurses, pharmacists and lay volunteers for its second "feeding" of trivalent vaccine May 3. Initial SOS day in the county was March 8.

Menard County Medical Society is facilitating service for its second SOS day May 3 with the publication of pre-registration applications in the local newspapers.

Williamson County Medical Society, which is sponsoring SOS days again this year, is donating surplus funds obtained from 25-cent fees collected during last year's program to the county's two hospitals.

CONTRIBUTION TO MEDICAL PROGRESS



Adams County Medical Society, represented by Dr. Richard Cooper of Quincy, left, made a significant contribution to medical education and progress in Illinois March 14 by donating check for $500 to the ISMS Educational and Scientific Foundation. Accepting for the Foundation are Drs. Newton DuPuy, center, Chairman of the ISMS Board of Trustees, and George F. Lull, Chairman of the Foundation.

Dr. Adams Nominated First Chairman Pro Tem



Dr. William E. Adams

Dr. William E. Adams, ISMS Trustee from the Third District (Cook County), was nominated as Chairman Pro Tem of the Board of Trustees at the Board of Trustees Meeting March 15.

The appointment, first of its kind to be made by the Board, will establish a smoother transition of duties from the outgoing to the incoming Board Chairman. Confirmation of this appointment will take place at the last Board session during the Annual Meeting in May. At that time Dr. Adams will officially replace Dr. Newton DuPuy, Quincy, who has served as Board Chairman since 1962.

Dr. Adams is Chairman of the Department of Surgery and James Nelson and Anne Louise Raymond Professor of Surgery at the University of Chicago.

COUNTY CAPSULES

BUREAU COUNTY hosted Dr. Robert H. West, Associate in Obstetrics-Gynecology at Northwestern U. March 10 when he spoke on "Management of Hemolytic Disease of the Newborn" at Perry Memorial Hospital in Princeton.

COOK COUNTY residents Dr. and Mrs. Max Meyerovitz, Chicago, celebrated their 50th wedding anniversary last month. Dr. Meyerovitz is a 50-year club member of ISMS.

GREENE COUNTY Medical Society began a Medical Self-Help Training Course March 10 in cooperation with the Greene County Civil Defense Department and the Home Economics Cooperative Extension Service. The program is part of the national goal to train at least one member of every family in the techniques of emergency medical care.

JO DAVIESS County Medical Society elected Dr. Delbert O. Williams, Stockton, president at its annual meeting Feb. 13.

KNOX COUNTY Medical Society will host Dr. Samuel M. Feinberg, Chief of Allergy, Northwestern University, at its meeting April 16. Dr. Feinberg will address the meeting on the subject, "Common Allergic Problems and Their Management."

LIVINGSTON COUNTY will hear Dr. Milton Tinsely, Associate Professor of Neurosurgery, Chicago Medical School, speak on "Head Injuries" at its meeting in Pontiac April 15.

MACON COUNTY Medical Society heard Dr. Lester Rudy, Clinical Associate Professor of Psychiatry, University of Illinois, speak on "Outpatient treatment by General Practitioners" at its meeting March 24.

County Society's Year a Busy One

How busy are county societies in looking after the needs of their members?

Plenty busy, as witness the following summary report of 1963 activities by the Logan County Medical Society:

January—a business meeting was conducted.

February—the Society assisted in the Medical Self Help Training Program offered by the U. S. Dept. of Health and Welfare. Over 300 persons completed the course.

March—New officers were installed and new committee chairmen appointed at a second business meeting.

April—A meeting was held in conjunction with the Logan County Bar Association.

May—Dr. Charles B. Bardwell represented the county as delegate to the Illinois State Medical Society.

June—a pharmacist-physician meeting was held and closer cooperation between the two groups was discussed.

August—a meeting was held with local funeral directors to discuss mutual problems.

September—Initial plans were laid for a county-wide polio immunization program.

October—Plans for Community Health Week were outlined which included a program to instruct primary and secondary school students in medical activities and to arouse their interest in medicine and allied professions as careers.

November—a meeting with the Lion's Club and representatives of the National Polio Foundation was held to formalize plans for an oral polio immunization program early in 1964.

In addition, the Grievance Committee heard three cases and a Mental Health Committee was named to act in cooperation with the county and state groups. Attendance at all of the meetings held averaged over 90 per cent!

Medical Business Meeting

The business side of medical practice—becoming increasingly important with the growing complexity of office management, submitting insurance claim forms and the tax structure—will be the topic of a special conference held in conjunction with the Annual Meeting at the Sherman House Thursday morning, May 21.

Sponsored by the ISMS Division of Economics and Insurance, the conference is being specifically planned to orient physicians in practical techniques of modern medical business management. Among the topics planned are: New Data Processing Equipment; Personal and Practice Management Services; and Credit and Collections.

Auxiliary members, who frequently assist in their husband's business office, will also find this conference of practical value and are urged to attend.

Scholarship Committee Meets



Programs encouraging promising students to become members of the medical profession or allied fields were discussed at a meeting of the Will-Grundy Medical Society Scholarship Committee last month. Committee members seated from left to right are: Dr. Robert Keener, Frankfort; Dr. William Dewitt, Joliet; Dr. John McLaughlin, Joliet; and Dr. John Roth, Morris. Standing from left to right are: Dr. James Lambert and Dr. James Hoffman, Joliet; and Robert C. Best, Executive Secretary of the Aesculapian Association of Will-Grundy County.

Medicine-Religion Committee Swings into Action—But Big

Production of a strip film . . . publication of a handbook . . . plus cosponsorship of a major meeting next month constitutes the ambitious program launched by the newly-formed ISMS Committee on Medicine and Religion.

Utilizing dramatic case histories, the strip film is designed to stimulate a mutual interest by both physicians and clergymen to work together as a "Health Team."

A supply of these films will be made available to county societies and local ministerial associations for use as an orientation "opener" at special meetings of physicians and clergy.

The handbook—which will offer practical guidelines of conduct for physicians and clergymen in best serving the total needs of the patient—will be distributed at these meetings.

"Spiritual Needs of the Sick" is the program to be presented by the Committee and the Catholic Physician's Guild of Chicago on Tuesday evening, May 19, at the Sherman House in Chicago. Held in conjunction with the Annual Meeting, it will feature outstanding physicians and clergymen discussing such subjects as: "Pastoral Care of Patient Needs"; "What Help the Physician Needs from the Chaplain"; "Communication Between Doctor, Patient and Chaplain"; and "An Analysis of the Jewish Chaplaincy."

The meeting is open to all physicians and clergymen.

Dr. Joseph R. Mallory, Mattoon, Chairman of the Committee, said: "We are hopeful that these efforts create a closer physician-clergy relationship that will reflect in a more active concern for the spiritual as well as physical needs of patients throughout the state."

TAKE ONE!



ISMS Trustee Dr. J. Ernest Breed, left, gets last minute instructions from TV producer Scott Craig, right, before filming statement on Kerr-Mills for "See Chicago," an hour-long documentary which will be seen over WBBM-TV next month. Although Dr. Breed will actually be seen for only a few minutes on the program, filming of his segment took more than two hours.

Firemen Register "Hot" MSHT Exam Scores

Chicago firemen—usually adept at putting out a blaze—started one last February by "burning up" the record book on the Medical Self Help Training course examination.

More than 1,000 Chicago area citizens took the exam, which was given at the conclusion of the ISMS-sponsored TV training course.

All of the 72 firemen taking it passed with an average 55-out-of-60 score, easily copping group honors. Individual honors went to firefighter trainee Robert J. Baldwin, 4623 South Union, Chicago, who was the only person to register a perfect score.

"These achievements didn't just 'happen'—they were the result of thorough preparation," declared Captain Sandino Guarascio of the department's training division.

"We incorporated as many of the TV lessons as possible into our own training program at the Academy," he declared. "We even held a recheck session after the exam was given."

Although the firemen took scoring honors, over 90 per cent of the persons taking the exam passed it and received their "degree"—an official Certificate of Achievement from the Illinois State Medical Society.

TICKER TAPE TO TIP M.D.'s AT MEETING

Illinois physicians won't have to lose touch with latest developments in the investment world while attending the Annual Meeting May 17-21.

Up-to-the-minute stock reports will be made available through a Dow-Jones ticker tape installed at the technical exhibit of Bacon, Whipple and Co. Investment Securities of Chicago.

The exhibit can be seen in Booth #56.

Additional services offered at the exhibit will be reports on various security and investment situations and an analysis of investment portfolios.

New Radio-TV Committee Formed

To continue the tremendous expansion of radio and TV activity begun in 1963, the ISMS PR Committee has appointed a new Radio and Television Subcommittee consisting of Drs. Robert E. Heerens, Rockford; Max Klinghoffer, Elmhurst; and Bertram Moss and Joseph Skom, Chicago.

According to the subcommittee chairman Dr. Leo P. A. Sweeney, the newly formed subcommittee will provide the Society with a specific arm to:

1. Plan, develop and promote programming for all ISMS radio and television presentations.
2. Regulate and control the quality of radio and TV appearances.
3. Recommend speakers for the ISMS radio-TV speaker's bureau.
4. Counsel county medical societies in radio and TV techniques.

In addition to maintaining the radio and television programming schedule which compiled a record 110 hours of public service broadcast time in 1963, the Committee will add several new programs in 1964.

1964 Auxiliary Convention Program Highlights



Mrs. Matthew E. Uznanski
President

WELCOME TO THE AUXILIARY CONVENTION!

It is an honor and a privilege to welcome you to the 36th Annual Convention of the Woman's Auxiliary to the Illinois State Medical Society. Share with us the experiences of a year replete with activity and productivity. Committees have been working for months to assure a program which will be informative and enjoyable. I cordially invite members and guests to attend the Convention and participate in functions planned for their enjoyment.

REGISTRATION — LOBBY FLOOR — SHERMAN HOUSE

Monday, May 18 ..... 5:00 P.M. to 7:30 P.M.
Tuesday, May 19 ..... 7:30 A.M. to 4:00 P.M.
Wednesday, May 20 ..... 7:30 A.M. to 4:00 P.M.

CONVENTION PROGRAM

TUESDAY, MAY 19 ..... GEORGE BERNARD SHAW ROOM

Formal Opening of 36th Annual Meeting ... 9:30 A.M.
Mrs. Matthew E. Uznanski, President, Presiding
Invocation ..... Reverend Edward J. Baranowski
Assistant Supervisor, Catholic Charities, Chicago
Pledge to the Flag .. Mrs. Kenneth L. Morris, President
Woman's Auxiliary to the Lake County Medical Society
Pledge of Loyalty ..... Mrs. W. J. Wanninger,
Past President, ISMS Woman's Auxiliary
Welcome ..... Mrs. Mitchell Spellberg, President
Woman's Auxiliary to the Chicago Medical Society
Response ..... Mrs. Donovan G. Wright, President
Woman's Auxiliary to the DuPage County Medical Society
Report of Credentials and Registration Committee
Mrs. Richard Icenogle, Chairman
Reading of the Convention Rules of Order .. Mrs. Percy Clark, Parliamentarian
Adoption of Convention Program
Announcement of Reference Committee Appointments
Appointment of Committee on Courtesy and Resolutions
Appointment of Election Committee
Appointment of Reading Committee
Convention Announcements ..... Mrs. Richard E. Westland, Convention Chairman
Greetings from the Illinois State Medical Society
Dr. Edward A. Piszczek
Address ..... Mrs. William H. Evans, President-Elect,
Woman's Auxiliary to the AMA
The Doctor's Wife In A Changing World
Presentation of the Budget ..... Mrs. Harold Dubner
Memorial Service .. Conducted by Mrs. N. A. Thompson
Past State Presidents Luncheon ..... 12:30 P.M.
Bismarck Hotel ..... Mrs. Wendell Roller, Chairman

OPEN HOUSE

President Suite — Hospitality — 2:00 to 4:00 P.M.
Chairman ..... Mrs. Alfred Pagano
Vice Chairmen, Mrs. G. Pastnack; Mrs. B. C. Schnell

Dinner and Theatre Party

Dinner—Martinique Restaurant ..... 6:30 P.M.
Drury Lane Theatre ..... 8:30 P.M.
"Claudia" featuring Jeanne Crain
Buses Leave Sherman House ..... 5:30 P.M.
Chairmen ..... Mrs. Henry Lewandowski; Mrs. Joseph Cari
Vice Chairmen ... Mrs. A. Pagano; Mrs. G. Pastnak

WEDNESDAY, MAY 20 ..... 8:00 A.M. to 8:45 A.M.

Continental Breakfast ..... George Bernard Shaw Room

Honoring County Presidents and Members-at-Large
Chairman ..... Mrs. Glen Harrison
Vice Chairman ..... Mrs. John E. Bohan
Original Skit ..... Mrs. Thomas W. Carter
"Out at the Chimney"

Round Table Discussions

"SAC" Activity Reports ..... 8:45 A.M. to 10:00 A.M.
Program ..... Mrs. John Koenig
Community Service ..... Mrs. Newton DuPuy
A.M.A.-E.R.F. Awards ..... Mrs. Joseph Lundholm
Aged ..... Mrs. John Van Prohaska
A.M.A.-E.R.F. ..... Mrs. Joseph S. Lundholm
Benevolence ..... Mrs. Allen S. Watson
Civil Defense ..... Mrs. John Malcolm Tindal
Community Service ..... Mrs. Newton DuPuy
Health Careers ..... Mrs. Alden Rarick
International Health .... Mrs. Earl S. Leimbacher
Legislation ..... Mrs. Walter Shriner
Special Projects ..... Mrs. Fred C. Endres
Mrs. John Van Prohaska
Mental Health ..... Mrs. Glenn R. Marshall
Organization, Membership ... Mrs. Willard Scrivner
Program ..... Mrs. John W. Koenig
Publication ..... Mrs. William Walton
Rural Health ..... Mrs. Eugene L. Vickery
Safety ..... Mrs. August Martinucci
Focus on 1963-1964 ..... County Presidents
Chairman ..... Mrs. Willard Scrivner

Mrs. Glen Harrison	Mrs. Kenneth Calhoun
Mrs. Donald Morehead	Mrs. Myer Shulman
Mrs. John W. Koenig	Mrs. H. E. Schoonover
Mrs. Holger Hoegh	Mrs. Thomas W. Kelso
Mrs. Silvio Del Chicca	Mrs. C. K. Wells
Mrs. A. W. Wellstein	Mrs. Harold McCann

Mrs. I. Erlin Bartlett

Round Table Discussion Reports ..... 11:00 A.M.

Speaker ..... Mrs. Haven Smith
National Chairman, American Farm Bureau Women
Subject ..... "We're in this Together"

LUNCHEON AND FASHION SHOW

Hotel Continental ..... 1:00 P.M.
Honoring Mrs. William H. Evans, President-Elect, Woman's Auxiliary to AMA and State Board Members
Chairman ..... Mrs. Bruno Beinoris
Vice Chairman ..... Mrs. Eugene L. Vickery
4:00 to 5:00 P.M. ..... Hospitality Room

THE ANNUAL DINNER ..... WEDNESDAY, MAY 20

Grand Ballroom ..... Sherman House
County Presidents, Hostesses
Hospitality Hour ..... 6:00 P.M.
Dinner ..... 7:00 P.M.

Thursday, May 21 — George Bernard Shaw Room — 8:30 A.M.

Parliamentary—"Know How" for "Early Birds"
Mrs. Percy Clark, Parliamentarian
Courtesy and Resolution Committee .. Mrs. Lewis Hare
Credentials, Registration Committee .. Mrs. R. Icenogle
Reference Committee Reports
Officers and Directors ..... Mrs. Wendell Roller
Councilors ..... Mrs. John Milroy
Standing Committees ..... Mrs. Frederick Roos
Action for the Budget for 1964-1965 .. Mrs. H. Dubner
Report of Nominating Committee .. Mrs. Wendell Roller
Election of Officers
Election of Delegates to Annual Meeting of Woman's Auxiliary to AMA
"Pedis Frigidi" ..... Dr. and Mrs. Howard Reiser and the Woman's Auxiliary to the Will-Grundy County Medical Society

INSTALLATION LUNCHEON

Bal Tabarin — Sherman House — 1:00 P.M.
Honoring
Mrs. Matthew E. Uznanski ..... Retiring President
Mrs. Williard Scrivner ..... Incoming President
Past State Presidents ..... Woman's Auxiliary
Installation of Officers ..... Mrs. John Van Prohaska
Hostesses ..... Woman's Auxiliary to the Chicago Medical Society and the Northwest Branch
Chairman ..... Mrs. Silvio Del Chicca
Vice Chairman ..... Mrs. Murray Fuchsmann
Program "The Sound of Music" ..... Sulie Hurand

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT

The Illinois Medical Assistants Association is seeking the help of ISMS members in raising the professional standards of the state's medical assistants.

The aims of the American Association of Medical Assistants and the Illinois chapter have been lauded by both the AMA and ISMS. All Illinois physicians are urged to encourage their medical assistants to become a part of this educational organization.

Demand Grows For Educational Facilities to Train Medical Assistants

Members of the Illinois Medical Assistants Association are frequently called upon to participate in "career days" that are sponsored by various high schools throughout the state. A recent poll taken by IMAA representatives who participated in such activities indicated that from 10 to 20 per cent of all high school youngsters showed a marked interest in making a career of one or another medical service profession. A significant number of these students requested more information about obtaining training as medical assistants.

IMAA members can give little or no advice to young people who seek education and training in the medical assistant area. This is because formal training as a medical assistant is not readily available in Illinois. IMAA members who are dedicated to improving the professional standards of their craft ask that physicians lend their influence and prestige toward convincing educational institutions of the need that exists for such training. Most IMAA members received "on-the-job-training." They are the first to admit that there are many areas in which they could stand improvement.

The primary purpose of IMAA is education. The Association was organized by a group of dedicated medical assistants who realized if they were to obtain the kind of "postgraduate training" they felt they required, they would have to furnish it themselves. There are 313 IMAA members in Illinois—12,000 in the U.S.

NOTICE TO PHYSICIANS ATTENDING ISMS CONVENTION:

Your medical assistants are invited to attend the Pathology Program on Wednesday, May 20.

They must, however, be accompanied by you to be admitted.

NEWS and ANNOUNCEMENTS

Dr. Edward Press Named Medical Assistant to Director of Illinois Department of Public Health

Dr. Edward Press, Chairman of the ISMS Environmental Health Committee, has been named medical assistant to the director of the Illinois Department of Public Health.

Dr. Press is now the public health director of the Evanston Health Department, assistant professor of pediatrics at Northwestern University School of Medicine, as well as visiting lecturer at the School of Public Health, University of North Carolina. He is currently a staff consultant for the Community Studies Project of the National Commission on Community Health Services.

His background includes maternal and child health work in the state health departments of West Virginia and Michigan. He was regional medical director of the U.S. Children's Bureau; associate director, University of Illinois, Division of Services for Crippled Children; and assistant professor of Preventive Medicine at the University of Illinois College of Medicine. He served four years as field director of the American Public Health Association, and another four years in the Medical Corps of the Army Air Forces.

On a national level, Dr. Press is chairman of four committees concerning hazards and accidents to children. He also presides over the Illinois State Medical Society Environmental Health Committee. He helped develop and was chairman of the first organized community poison control center (Chicago). He received the 1961 American Academy of Pediatrics Clifford G. Grulee Award—and Gold Medal—for contributions to the health and welfare of children through his poison control activities.

Dr. Press has written many articles for publication in professional journals in the fields of medicine, public health and nursing. He has also authored a book on "Accidental Poisoning in Childhood," published by the American Academy of Pediatrics.

Dr. Press holds a B.A. from Ohio University, an M.D. from New York University College of Medicine, and an M.P.H. from Harvard School of Public Health. He is a licentiate of the American Board of Pediatrics and has been certified by the American Board of Preventive Medicine.

Professional associations in which Dr. Press holds membership include life fellowship in the American Public Health Association; membership in the American Medical Association and its local county and state societies, fellowship in the American Academy of Pediatrics, American College of Preventive Medicine, Institute of Medicine of Chicago, and membership in the Royal Society of Health (England). He is also past president of the Illinois Association of Medical Health Officers.

ABC Commentator to Address Fifty Year Club Luncheon



Alex Dreier

The principal speaker at the annual meeting's Fifty Year Club luncheon will be Alex Dreier, well-known ABC news commentator. The subject of his address is, "Where Do We Go From Here?"

First Chicago Physician To Join S. S. Hope

The first Chicago area physician to join the S. S. HOPE will be William F. Rowley, M.D., a pediatrician on the staff of Children's Memorial Hospital. Dr. Rowley is a graduate of Marquette University School of Medicine and a member of the American Academy of Pediatrics. He has been interested in the project for some time and has made certain that all of the interns working at Children's Memorial have had an opportunity to view the "HOPE in Peru" film. He will leave on May 1st to join the ship in Guayaquil for a two month tour.

SALES TAX ON VACCINE FOR MASS IMMUNIZATION

Purchases of vaccine for mass immunization by county medical societies or other voluntary associations may be subject to the Illinois Retailers' Occupation Tax. Dr. Norman J. Rose, of the Illinois Department of Public Health, has discussed this matter with the Department of Revenue. He was informed that purchases by a not-for-profit association are not *per se* exempt from imposition of a sales tax. In order to be thus exempt, the organization must be devoted exclusively to religious or charitable purposes.

Significantly, purchases by governmental agencies are exempt from the tax. It was therefore suggested that county health departments or municipal boards of health that participate in mass immunization programs buy vaccines through a government agency.

Dr. David A. Bennett

Dr. David A. Bennett died unexpectedly at his Canton, Illinois, home on March 9, 1964. Born on Jan. 25, 1908, Dr. Bennett was 56 years old when he passed away. He is survived by his widow (Ruth Benson Bennett), his daughter (Mrs. Charles Williams), his sister (Mrs. Ruth Carlson), and a grandson.

After graduating from the University of Illinois College of Medicine in 1932, Dr. Bennett completed a two-year internship at the Cook County Hospital. He practiced medicine in Canton from 1934 to 1942. From July, 1942, to March, 1946, he served as a navy lieutenant commander. He was assigned to duty with the marine corps. Since 1946 he had been associated with the Coleman Clinic in Canton.

Dr. Bennett was a member of the Fulton County Medical Society, the Illinois State Medical Society, and the American Medical Association. He was also a fellow of the American College of Surgeons, the International College of Surgeons, and the American Board of Surgery. He was president-elect of the Illinois Surgical Society, and was to have assumed office in May.

Announcements

Annual Otolaryngologic Assembly

The Department of Otolaryngology of the university of Illinois College of Medicine and the new Illinois Eye and Ear Infirmary at the Medical Center, Chicago, will present an in tensive postgraduate basic and clinical program from October 3 through October 9, 1964. Emanuel M. Skolnik, M.D., Professor of Otolaryngology and Chairman of the Assembly will direct the program.

This assembly for practicing otolaryngologists offers a condensed one week program. It is designed to bring fundamental information and a wide variety of current advances in medical and surgical management to specialists. Basic sciences are reviewed by means of discussions augmented by visual aids.

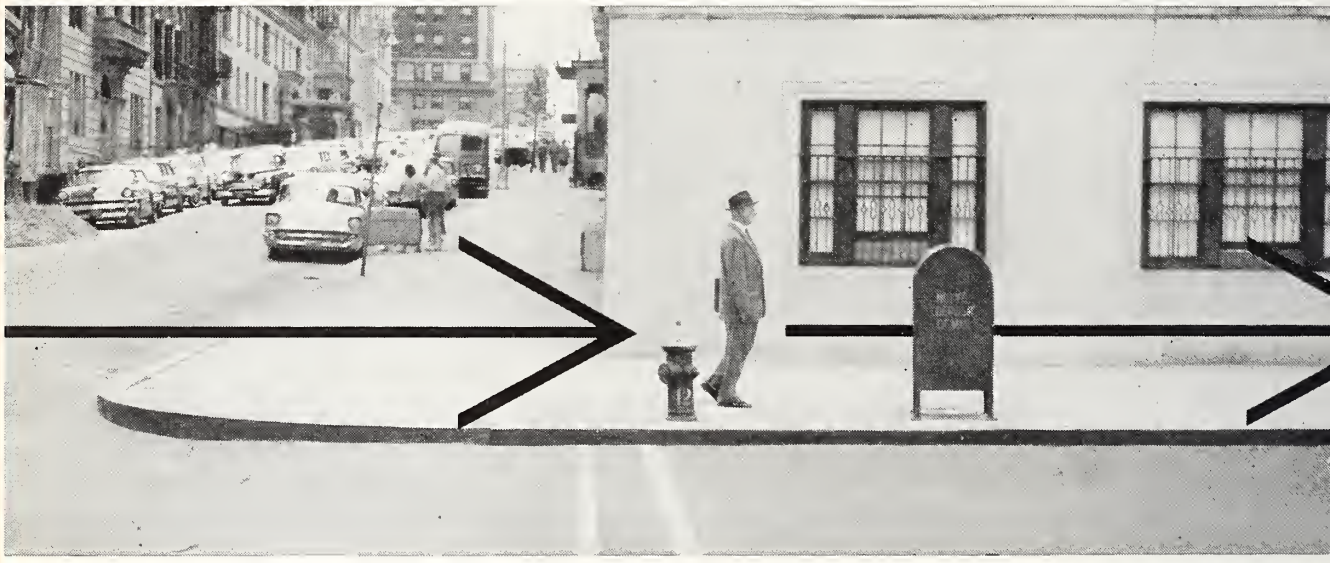
Panel sessions have been designed to emphasize otologic and reconstructive surgery, tumors of the head and neck, otoneurology, and audiology. Luncheon chats with question and answer periods are an important part of the daily instructional program.

Interested physicians should direct communications to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago, Illinois, 60612.

Chicago Society of Medical Jurisprudence Meets

The Chicago Society of Medical Jurisprudence held a meeting on April 9, 1964. The speakers for the evening, and their topics were: **John H. Kenelly,** *Airplane Disaster Litigation and Medical Aspect;* **Dr. George W. Homes,** *Pulmonary Disability Incurred Secondary to Traumatic Injury of the Chest.*

Notices of future meetings of this organization will be published in the *Journal* so that physician-members of ISMS who are interested in medical jurisprudence may attend.



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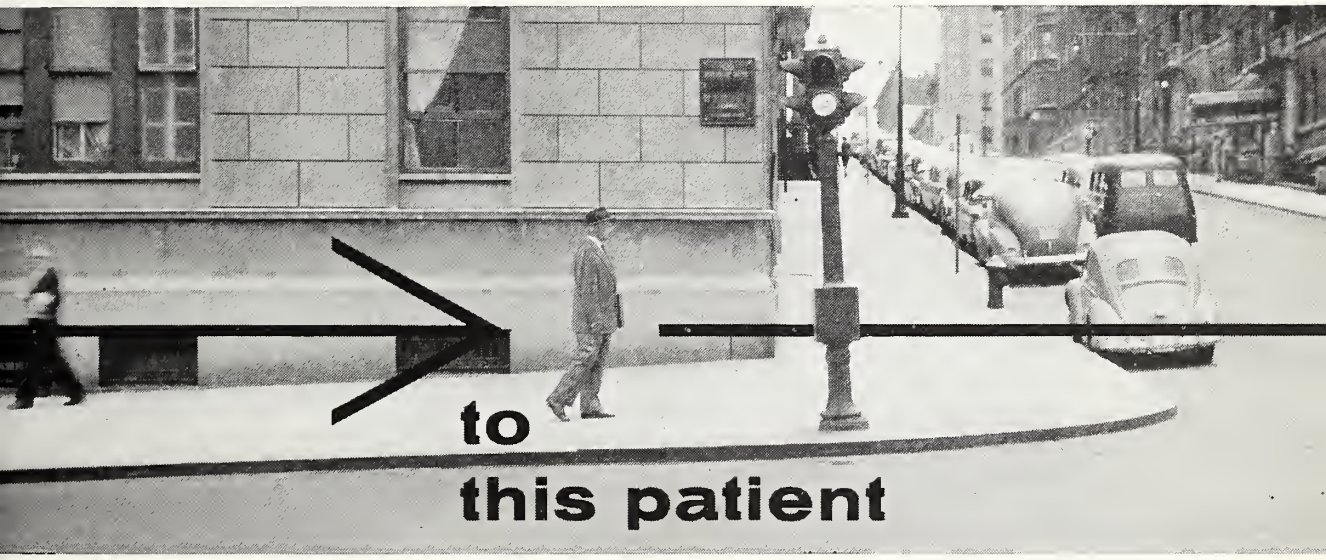
Kennedy Foundation Donates $2,200,000 To U of C For Research On Mental Retardation

The Joseph P. Kennedy, Jr., Foundation has committed $2,200,000 for construction of research facilities in mental retardation at the University of Chicago. U.S. Senator Edward M. Kennedy (Massachusetts), President of the Foundation, announced the gift. Dr. George Wells Beadle, President of the University of Chicago, described its use.

The Foundation has awarded $1,500,000 to the University for establishment of the Joseph P. Kennedy, Jr., Mental Retardation Research Center, including a mental retardation clinic. It will be located in the University's new Children's Hospital. In addition, the Foundation has pledged $700,000 to assist in establishing the Joseph P. Kennedy, Jr., Mental Retardation clinical services and training facility. This sum will be available to meet the requirements of the three-to-one matching provision in the new federal mental retardation program for such facilities. If the University's application is approved, an additional $2,100,000 will become available for construction of the clinical services and training facility.

The proposed mental retardation clinical services and training facilities will involve a number of different academic units in research and training programs. These will include the graduate schools of medicine, education, and social service administration, and the department of psychology and other areas of the Division of the Social Sciences.

Dr. Albert Dorfman, Chairman of the University Department of Pediatrics, will be the director of the Mental Retardation Research Center. Dr. Dorfman is a professor of both pediatrics and biochemistry. He is director of the La Rabida-University of Chicago Institute.



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(Continued from page 467)

Increase in Rubella Cases

Dr. Franklin D. Yoder, director of the Illinois Department of Public Health, announced that Illinois has shown an 86 per cent increase in reported rubella (German measles) cases for January 1-March 15 period over the same period for 1963. These statistics, Dr. Yoder said, were reported in the latest publication of the U.S. Public Health Service.

The increase, which has been noted in all areas of the state, is especially high in Kane, Lake, LaSalle, Logan, McLean, Piatt, Warren, and Henry counties. These eight counties have reported more rubella cases for the first 12 weeks of 1964 than they did for all of 1963.

The federal report stated that the disease appeared to be under-reported in Illinois. This was based on the number of requests received by gamma globulin for pregnant women who have been exposed to rubella.

Northwestern University Medical Faculty-Alumni Reunion Dinner Announced

The Medical Division of the Northwestern University Alumni Association has announced that the annual medical faculty-alumni reunion dinner will be held on Saturday, May 23, in the Gold Coast Room of the Drake Hotel in Chicago. A tour of the new building will begin at 4:00 P.M., starting from the Montgomery Ward Building. A social hour commencing at 6:00 P.M. will be followed by dinner at 7:00 P.M. The dinner is for couples. Tickets are $10.00 per plate. Reservations should be made at the Medical Alumni Office, 303 E. Chicago Ave., Chicago 11, Illinois.

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(Continued from page 468)

Hospital Sisters Form Blood Donor's Club

Sisters of the Holy Family of Nazareth have formed a blood donor's club in cooperation with the Community Blood Center, Inc., of Chicago. According to Gilbert Rossner, Director of the Center, the Sisters are the first religious order to form such a club.

On March 14, 1964, 60 Sisters from St. Mary of Nazareth Hospital travelled to Des Plaines, Illinois, to assist in the drawing of blood.

Foreign Fellowships Awarded to Medical Students From Illinois

The Association of American Medical Colleges has announced that twenty-nine junior and senior medical students from the U.S. have been awarded fellowships to study in foreign lands. These fellowships will enable the students to obtain supervised medical experience in relatively under-developed areas such as Southeast Asia, Africa, Central and South America, and Oceana.

Two of the 29 fellowship winners are from the state of Illinois. They are: Lawrence D. Edwards, of Macomb, Illinois, a junior at the University of Illinois College of Medicine; and John P. Hinterkopf, of Peru, Illinois, a junior at Northwestern University Medical School. Mr. Edwards, who will be accompanied by his wife Ann, will be assigned to the Sudan Interior Mission Hospital, Soddu, Ethiopia. Mr. Hinterkopf has been assigned to the Sudan Interior Mission Hospital, Shashemane, Ethiopia.

SKF Grants

The fellowships are made available by grants from Smith Kline and French Laboratories. Including the current selections, a total of 152 fellowships have been issued during the past five years. Winners are selected by a committee of six U.S. medical educators. Each fellow spends at least 10 weeks with his foreign sponsor. The stipend accompanying each award differs according to individual requirements.

(Continued on page 472)

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(Continued from page 470)

FDA's Determination to Assume More Power Is a Source of Concern

Robert J. Benford, M.D., Director of Medical Relations for the Pharmaceutical Manufacturers Association, has expressed grave concern over the FDA's campaign to assume unlimited power over medical matters and matters of opinion. In a recently-issued PMA bulletin, Dr. Benford stated:

"As an alumnus of the FDA, I have a friendly feeling for that organization. Despite that I must oppose the unlimited power it is seeking over medical matters and matters of opinion. I cannot forget that the first chief of FDA started out wrong on the toxicity of saccharin and benzoate of soda. His successors from top to bottom, being mere mortals, will inevitably be wrong many times again. The progress of medicine, the development of new and better tools for our physicians is a cause that makes it critically urgent that there be more ample opportunity for review by appeal of others of decisions of this agency."

Doctor's Problem of "Informational Indigestion" to be Studied

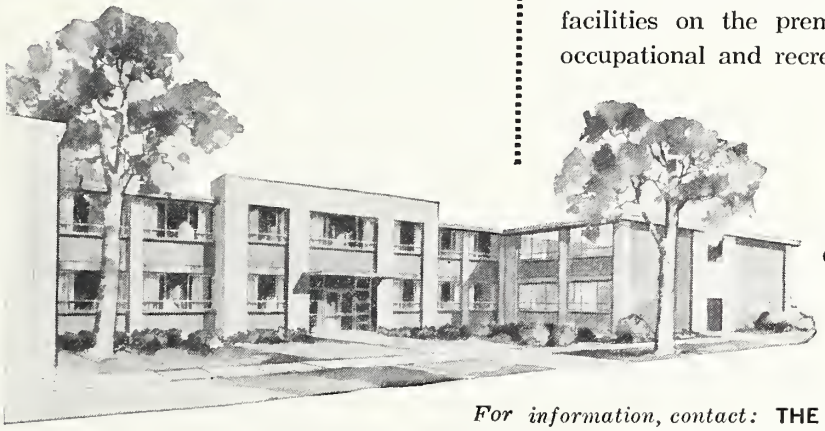
Columbia University sociologists claim that most physicians suffer from what may be called "informational indigestion." Allegedly this condition attacks the doctor when the tremendous volume of new information generated by medical research destroys his capacity to learn and use it. The NIH has given the University's Bureau of Applied Social Research $36,000 to study the new-fangled "malady."

Dr. Herbert Menzell, Columbia research associate, and a team of interviewers will ask approximately 1,000 U.S. doctors how they receive current medical information. The team will also probe each physician's knowledge of current medical news. It will consider each physician's training, background, and working environment. It will attempt to learn what medical literature he reads, what medical conferences he attends, and what postgraduate courses he takes. The survey is to be completed in the spring of 1965. Results will be made available in published articles.

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Obituaries

George F. Asselin*, Mount Prospect, died March 21, aged 88. Having retired from the practice of psychiatry in 1950, Dr. Asselin graduated from Loyola University School of Medicine in 1911.

Orville E. Black, Buffalo, died January 29, aged 76. Retired in 1951, Dr. Black was a graduate of Loyola University School of Medicine in 1917.

Arthur A. Clyne*, Belleville, died March 8, aged 56. He was a graduate of Universitat Leipzig Medizinische Fakultat, Saxony, Germany, in 1933, specializing in Obstetrics and Cynecology.

George W. Dawson, Jr., Chicago, died February 24, aged 64. In 1932 he was a graduate of Rush College after which he practiced both psychiatry and general medicine.

Arthur G. deRevey, Rossville, originally from Munkacz Hungary, came to the United States in 1921 and specialized in E.E.N.T.

Edward A. Diestelmeier*, Freeport, died March 2, aged 83. He was a graduate of the Illinois Medical College in 1910.

Nicola Emanuele*, Oak Park, died March 10, aged 68. He was a graduate of the Royal university of Naples and was awarded the cross of solidarity by the Italian government in World War II.

Neil A. Esposito*, Minonk, died February 9, aged 46. He was a graduate of Chicago Medical School in 1944 and a veteran of World War II.

John M. Gillespie*, Marion, died in March. He was a graduate of Barnes Medical College, St. Louis, in 1905.

Moses W. Harrison*, Collinsville, died February 13, aged 87. In 1898 he was a graduate of the St. Louis College of Physicians and Surgeons and a pioneer in the treatment of tuberculosis and lead poisoning.

L. Merrill Henikoff, Chicago, died March 10, aged 67. In 1921 he was a graduate of The Hahnemann Medical College.

Mark J. Hughes*, Grand Tower, died February 20, aged 58. He was a graduate of the University of Illinois College of Medicine in 1932 and a World War II veteran.

Herbert B. Henkel*, Springfield, died in March. He was a graduate of St. Louis University School of Medicine in 1944 and a specialist in the field of urology.

Harry L. Logan*, Salem, died March 6, aged 80. In 1905 he was a graduate of St. Louis University School of Medicine.

Francis G. Schmidt, Sr., Robinson, died June 6, aged 81. In 1906 he was a graduate of the Illinois Medical College.

Francis C. Sedlak*, Cicero, died February 23, aged 53. He was a graduate of the University of Illinois College of Medicine in 1936.

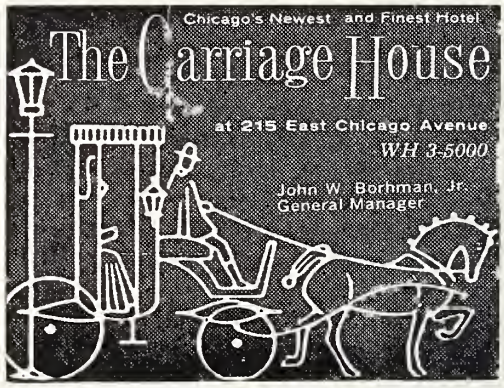
Harold E. Silverman*, Chicago, died March 8, aged 59. He was a graduate of University of Illinois College of Medicine in 1930 and head of obstetrics and gynecology at Grant Hospital.

James P. Simonds*, Chicago, died March 19, aged 85. In 1907 he was a graduate of Rush Medical College, specializing in pathology.

Solomon W. Smith*, formerly of Chicago, Pasadena, California, died March 18, aged 82. After graduation from Meharry Medical College in 1914 he did graduate work at Stanford University.

Arthur W. Woods*, Chicago, died March 16, aged 85. A graduate of Northwestern University Medical School in 1904, he had served on the staffs of Englewood, St. Francis, Little Company of Mary and Roseland Community Hopsitals. He was an emeritus member of ISMS.

**Indicates member of Illinois State Medical Society.*



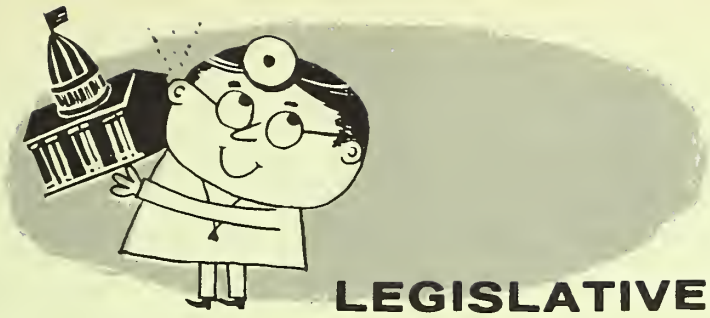


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LEGISLATIVE LISTENING POST

May, 1964

ROSTENKOWSKI FOR O'BRIEN ON WAYS & MEANS COMMITTEE

Democratic Congressmen of Illinois have unanimously nominated Dan Rostenkowski of the 8th Congressional District of Chicago to succeed the late Thomas J. O'Brien (Dem-6th Dist.) on the important House of Representatives Ways and Means Committee. Rep. Rostenkowski, in a recent televised interview, stated that he will support President Johnson's Medicare Program and hopes to get the bill out of Committee to the House floor for action soon. Rostenkowski's appointment is not expected to alter the voting complexion of the Ways and Means Committee. Alderman Daniel A. Ronan, Democratic 30th Ward Committeeman, Chicago, has been slated to replace O'Brien.

PRIVATE HEALTH INSURANCE COVERAGE FOR THE ELDERLY

During the April 27-30 hearings of the MacNamara Senate subcommittee on the Health of the Elderly, Minority Leader Everett M. Dirksen (R-Ill.) issued an opening statement in praise of voluntary health insurance as a new force in corporate initiative. Walter M. Foody, Vice-President, Continental Casualty Company of Chicago, appearing as a witness, stated that 800 firms now write health insurance policies covering some 10 million of the elderly. Walter J. McNerney, President of Blue Cross Association and Robert Evans, Executive Vice President of the Chicago Blue Cross-Blue Shield plan also testified.

Democratic members of the subcommittee disputed Foody's contention that 60% of the 17 or 18 million Americans over 65 are adequately covered by private health insurance. Witnesses for the Public Health Service and the Social Security Administration testified that more than 8 million Americans lack any kind of health protection. The Senate subcommittee is attempting to find out whether private insurance firms are providing adequate health care plans for older persons at reasonable prices.

APPROPRIATION OF FUNDS FOR TB CONTROL RESTORED

The Fogarty subcommittee of the House of Representatives recently restored and increased the Budget Bureau's reduced 1965 appropriation for TB Control. The

Budget Bureau projection of $6,364,000 was raised by the subcommittee to $10,364,000. The appropriation will allow continuance of the Tuberculosis Control Program of the Illinois State Department of Public Health and other such programs in the nation. The Illinois State Medical Society supported the restoration of TB control funds temporarily since no alternate state financing would be possible until after the General Assembly meets in 1965.

MEDICAL CORPORATION TAX EQUALITY

Congressman Robert McClory (R-Ill.) has introduced a bill (H.R. 9874) amending Section 7701 of the IRS Code of 1954 to provide that professional corporations formed under state law would be for tax purposes considered as other corporations. The IRS had previously issued regulations which would, in effect, discriminate against professional corporations. ISMS testified on March 4 at public hearings in opposition to the new regulations.

HOSPITAL LICENSING CHANGES TO BE RE-INTRODUCED

State Senator Arthur R. Gottschalk (R) speaking at a press conference April 29, during the annual Tri-State Hospital Assembly, noted that, "several attempts have been made by crime syndicate interests to enter the hospital field." Sen. Gottschalk said he plans to re-introduce a bill in the next Assembly to tighten the hospital licensing laws and prevent crime syndicate in-roads. A similar bill last session was tabled pending further study.

The Illinois State Medical Society, Legislative Committee has been exploring possible changes in the hospital licensing law as part of the agreement reached in connection with Senator Gottschalk's previous bill. A special legislative subcommittee, chaired by Dr. H. Close Hesseltine, has been working in conjunction with the Chicago Hospital Planning Council, the Illinois Hospital Association, the Illinois Academy of General Practice, and the Illinois Department of Public Health in an effort to reach agreement on suitable wording to control unnecessary hospital building and undesirable sponsorship.

HOSPITAL COMMERCIALIZATION CONDEMNED

The Hospital Planning Council for Metropolitan Chicago has been asked by the Chicago Committee on Hospital Development to take a stand against hospital construction of profit-producing doctors' offices. The Chicago Committee, representing real-estate interests, has been conducting a campaign to prevent hospitals from building doctors' office buildings in connection with hospitals. This group has previously stated that operation of doctors' office buildings by hospitals puts them in competition with commercial buildings. The Hospital Planning Council was told that, "your influence should tip the scales against this trend that has already led to the creeping commercialization of a number of non-profit hospitals here."

EXPANSION OF KERR-MILLS STATE IMPLEMENTATIONS

Considering the sustained pressure for medicare legislation, it is of importance to note the following tabulation which shows the expansion of Kerr-Mills activity compiled by the American Medical Association. MAA programs are in effect in 36 states; 5 states enacted legislation in 1963; 4 state legislatures are considering action; 3 states authorized programs; only 6 states have not acted to implement Kerr-Mills. This favorable rate of implemention reflects the value of the Kerr-Mills program.

STATE IMPLEMENTATION OF KERR-MILLS
(Medical Assistance to Aged - MAA)

APRIL 1, 1964

	INTRODUCED	ACTION TAKEN	PROGRAM OPERATING
Alabama	1961	enacted 1961	Feb. 1962
Alaska	1964	--	--
Arizona	1964	passed House	
Arkansas	No implementing legislation required per Attorney General		Sept. 1961
California	1961	enacted 1961	Dec. 1961
Colorado	1963 - 1964	enacted 1964	
Connecticut	1962	enacted 1962	April 1962
Delaware	--	--	--
District of Columbia	1963	enacted 1963	April 1963
Florida	1963	enacted 1963	July 1963
Georgia	1961	enacted 1961	No funds available
Guam	1962	enacted 1962	June 1962
Hawaii	1961	enacted 1961	July 1961
Idaho	1961	enacted 1961	July 1961
Illinois	1961	enacted 1961	Aug. 1961
Indiana	1963	Governor veto over-ruled State Supreme Court 2/64	Jan. 1965
Iowa	1961	enacted 1961	Started Dec. 1963
Kansas	1963	enacted 1963	Jan. 1964
Kentucky	1960	enacted 1960	Mar. 1961
Louisiana	1961	enacted 1961	Dec. 1961

STATE IMPLEMENTATION OF KERR-MILLS - Continued

	INTRODUCED	ACTION TAKEN	PROGRAM OPERATING
Maine	1961	enacted 1961	Oct. 1961
Maryland	No implementing legislation required per Attorney General		June 1961
Massachusetts	1960	enacted 1960	Oct. 1960
Michigan	1960	enacted 1960	Oct. 1960
Minnesota	1963	enacted 1963	July 1964
Mississippi	1964	--	--
Missouri	1963	enacted by legislature, vetoed by Governor 1963	
Montana	1963	died in Committee 1963	
Nebraska	1963	enacted 1963	Jan. 1964
Nevada	1963	enacted contingent upon tax referendum; defeated	
New Hampshire	1961	enacted 1961	Sept. 1961
New Jersey	1962	enacted 1963	July 1963
New Mexico	No implementing legislation required per Attorney General		Appropriation pending 1964
New York	1961	enacted 1961	Apr. 1961
North Carolina	1963	enacted 1963	Not started
North Dakota	1961	enacted 1961	July 1961
Ohio	1963	voted down 1963	
Oklahoma	No implementing legislation required per Attorney General		Dec. 1960
Oregon	1961	enacted 1961	Oct. 1961
Pennsylvania	1961	enacted 1961	Jan. 1962
Puerto Rico	No implementing legislation required per Attorney General		Jan. 1962
Rhode Island	1963 - 1964	voted down 1963	
South Carolina	1961	enacted 1961	July 1961
South Dakota	1963	enacted 1963; amendments required by HEW passed 1964	Upon approval of plan
Tennessee	1961	enacted 1961	July 1961
Texas	Referendum slated		
Utah	1961	enacted 1961	July 1961
Vermont	1962	enacted 1962	July 1962
Virgin Islands	1960	enacted 1960	Feb. 1962
Virginia	1962	enacted 1962	Jan. 1964
Washington	No implementing legislation required per Attorney General		Oct. 1960
West Virginia	1960	enacted 1960	Oct. 1960
Wisconsin	1963	enacted 1963	July 1964
Wyoming	1963	enacted 1963	July 1963

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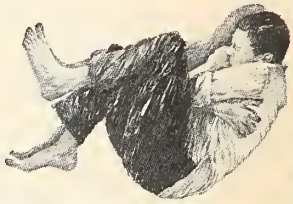
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AS I SEE IT FROM '360'

By Robert L. Richards
Executive Administrator

Political Education For Physicians

Every practicing physician is constantly obliged to deal with disease, pain, suffering, and death. No matter how inured he may think he has become to these entities, the physician can never attain an absolutely objective attitude toward them. To put it bluntly, he hates them as much—if not more—than anyone outside the medical profession does.

Yet, whether he likes it or not, the physician is the only kind of professional person who is qualified to cope with disease, pain, suffering, and even death. This is because he has been specifically educated, trained, and legally endorsed to perform all functions that attend the healing arts.

Today's physician, whether he likes it or not, is confronted with another kind of hateful problem. He is not, however, specially educated, trained or endorsed to cope with it. This is because the problem is of a political, rather than a medical, nature. Every doctor knows, for example, that the government has begun to proliferate into activities which pertain directly and indirectly to the medical profession. This gross interest and inquiry into the practice of medicine has its etiology in and with basic politics and politicians.

For obvious reasons, the politician cannot practice medicine. On the other hand, very few physicians are sufficiently conditioned—either by nature, inclination, or training—to deal with political problems. It is for this very reason that doctors generally feel that they should not become involved in the "dirty infighting" of the political arena.

We heartily agree with this sensible policy. The physician should not be mixed up about politics. He should be as completely well informed as he can possibly be about all political matters. Thus the Board of Trustees advocates complete political education for the physician. Education is one of the important functions of your Illinois State Medical Society. In fact, one major program of ISMS—the Public Affairs Committee—is devoted exclusively to the cause of political education.

No physician ever hesitates to call in additional expert advice when he feels that one of his patients requires specialized attention. For a similar reason, we feel that the physician should also have political specialists to whom he can turn for advice and consultation. The Public Affairs Committee serves this purpose. Its members—each of whom is a political expert—are available for consultation and advice to the physician as his "specialists in political affairs."

The specific functions of each Committee member are to enlighten physicians about the roles they can play as "opinion makers," and also to assist county medical societies in the organization and implementation of programs which are consistent with the medical profession's ideals.

If the medical profession is to prevent politicians from taking over and running medicine, physicians must prepare themselves to work as politicians in both major political parties, and—yes—as organized independents if this turn of events is thrust upon them.



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"Health Statesmanship"

Dr. H. Close Hesseltine has made some pertinent comments regarding the AMA stand on cigarette smoking. These comments were published in the Chicago Tribune. We think they are significant enough to be reprinted here.

"Chicago, April 15—Miss Sheila Wolfe reported in the Chicago Tribune (April 2) that Dr. Thomas Carlisle of Seattle, a radiologist, had taken a strong exception to the American Medical Association's statement on cigarette smoking. The source of my information is similar to Dr. Carlisle's, but I disagree with him.

Habituation or addiction to cigarette smoking through inhalation is known. The increased risks by inhalation have been identified. There is no logic to support inhalation of smoke, and no physiologic benefit through it.

Even so, it seems that tabacco is here to stay for some time, and that cigarettes will not vanish. If this vision is correct, then would it not be most logical in the immediate future to initiate programs to understand more about tobacco and its effects? Perhaps cultivation, treatment, or processing could be used to reduce or remove harmful agents.

The proposal to study and educate is as American as apple pie. The research program of the American Medical Association should contribute to the public education and comprehension of menacing factors in cigarette smoking.

The statements of risks or dangers in other areas are often ignored. For instance, the improper or excessive use of food, drink, exercise, recreation, work, and even play, become involved in the individual's health. Some may remember William Jennings Bryan, a great advocate of temperance. His reference in temperance was to alcohol, but he literally killed himself by overeating.

Perhaps a number of people feel more righteous by protesting about cigarettes, but is it not far better to investigate the whole problem than merely to protest, and accomplish little? Thus, the American Medical Association's position is one of health statesmanship. Indeed, I commend the AMA for taking leadership in studying the problem."

—H. Close Hesseltine, M.D.

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Development of the Nephrotic Syndrome Secondary to Renal Vein Thrombosis in a Patient With Bronchogenic Carcinoma and Hodgkin's Disease

Richard Foth, M.D.*, Karl Bader, M.D.**, and Robert Kark, M.D.***

Cardinal findings which are commonly associated with the nephrotic syndrome include conditions such as edema, proteinuria, hypercholesterolemia, and hypoproteinemia. These and other well-established "classic" findings are not, however, the only conditions to be linked with the syndrome. This was brought out in 1958 by Kark[4] and his associates. They compiled a comprehensive review of cases which indicated that a wide variety of devious etiological factors may be identified with the nephrotic syndrome.

Recent diagnoses have indeed demonstrated that the nephrotic syndrome can masquerade under the guise of many baffling and intriguing symptoms. For example, renal thrombosis is not frequently suspected as a cause of the nephrotic syndrome—yet the case to be presented here describes an instance in which the nephrotic syndrome definitely developed secondary to renal vein thrombosis.

*Resident in Medicine, Presbyterian-St. Luke's Hospital; **Resident in Surgery, Presbyterian-St. Luke's Hospital; ***Professor of Medicine, University of Illinois College of Medicine, and also Attending Physician, Presbyterian-St. Luke's Hospital, Chicago, Illinois.

From the Department of Medicine, Presbyterian-St. Luke's Hospital, Chicago, Illinois. This study was supported in part by a grant from the Kidney Foundation of Illinois.

Case History

A. R., a 57-year-old milk truck driver, was in apparent good health until July of 1959. At that time he complained of recurrent epigastric distress. X rays of the stomach indicated an ulcer on the lesser curvature. Chest x rays showed a small superior mediastinal mass on the right (figure 1). After treatment with a standard ulcer regimen—as prescribed by his physician—he enjoyed prompt relief of his distress.

First Hospital Admission

In the spring of 1960 the patient developed a dry persistent cough. Progressive swelling of both legs was also noted. He was admitted to the hospital, where physical examination revealed marked edema of the legs. This edema extended a third of the way up the thighs. There was no evidence of collateral circulation over the abdomen.

The patient's blood pressure was 130/70. Hb was 14 gm per 100 ml. The white blood cell count was



Figure 1

Chest X-rays showing enlargement of a superior mediastinal mass and development of a pleural effusion.

9,300 per cu mm. A 24-hour urine collection contained 13.8 gms of protein. An Addis count revealed 16,000 casts per cu mm, 480,000 red blood cells per cu mm, and 592,000 white blood cells per cu mm. Sedimentation rate was 94 mm per hour, BUN was 20.5 mg per 100 ml, and cholesterol was 399 mg per 100 ml. Serum electrophoresis read 3.7 gm per cent of total protein, albumin was 0.6 gm per cent, alpha 1-globulin 0.2 gm per cent, alpha-2 globulin 1.5 gm per cent, beta globulin 0.7 gm per cent, and gamma globulin 0.7 gm per cent. There was 50 per cent retention of dye during a Congo Red test.

Chest X ray revealed an increase in the size of the right hilar mass. An intravenous pyelogram showed faint visualization of the collecting system of the right kidney. The left pyelogram did not visualize.

Biopsy of a cervical lymph node was interpreted as chronic hyperplasia. The patient was thought to have a mediastinal tumor and nephrosis of unknown etiology. *Triamcinalone,* in a dose range of 16-to-30 mg per day, was instituted—along with diuretics. The edema gradually disappeared, and the patient felt better until November, 1960, at which time he was hospitalized once more.

Second Hospital Admission

About three weeks prior to this hospitalization the patient had developed rather sudden and severe swellings about the head, neck, shoulders, and arms. This edema was unrelenting. When shortness of breath ensued a few days later, he was referred and admitted to Presbyterian-St. Luke's Hospital.

Physical examination revealed marked swelling due

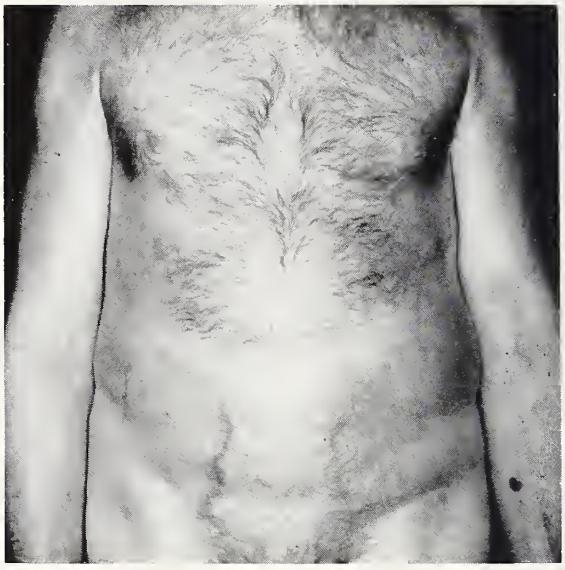


Figure 2

Prominent collateral veins visible over lower thorax and abdomen.

to edema of both arms with lesser degrees of edema involving the face, neck, and thorax. The edematous area was strikingly demarcated at the costal margin. There was only a trace of ankle edema.

A prominent venous pattern had developed over the lower thorax and abdomen. Venous filling was noted to be from above. The jugular veins were firm and engorged, but the fundascopic examination did not reveal particularly dilated venules.

The blood pressure, as ascertained over the popliteal arteries, was 130/80. The pulse was 84 per minute, respiration was 32 per minute. The patient was moderately dyspneic at rest. Examination of the thorax demonstrated decreased breath sounds and dullness at the right base.

There were two other physical findings which were considered to be remarkable. The first was the appearance of Muerke's lines—white, opaque lines that traversely crossed several finger nails. The presence of these lines was attributed to hypoproteinemia. The second remarkable finding was a firm, smooth, slightly tender liver palpated about eight centimeters below the right costal margin.

Laboratory Examinations

Hb was 9.8 per 100 cc. White blood cells were 14,200 per cu mm, with a normal differential. Serum sodium was 139 meq per L; chlorides, 96 meq per L; potassium, 3.3 meq per L; and carbon dioxide combining power, 22.7 meq per L. BUN was 34 mg per 100 ml; serum creatinine, 1.7 mg per 100 ml; calcium, 7.3 mg per 100 ml; and phosphorus, 4.9 mg per 100 ml. Cholesterol was 440 mg per 100 ml.

Serum electrophoresis revealed a total protein of 3.9 gm per cent, with a marked hypoalbuminemia and an

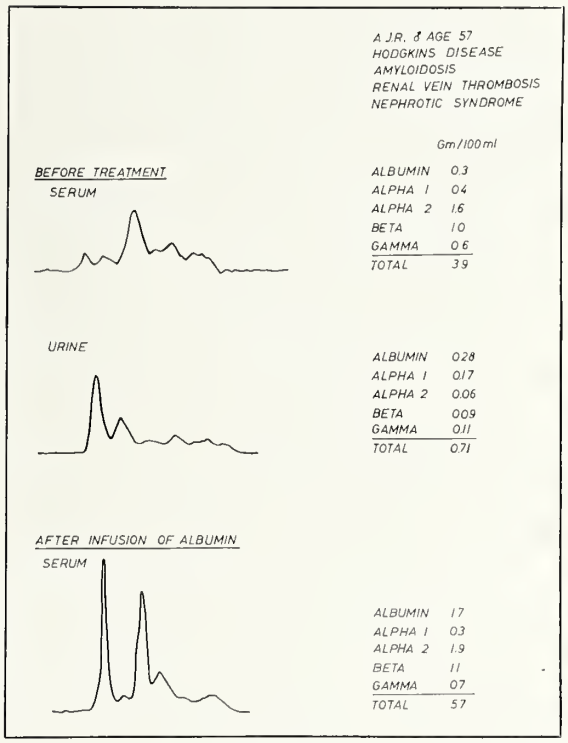


Figure 3

Electrophoretic patterns before and after treatment.

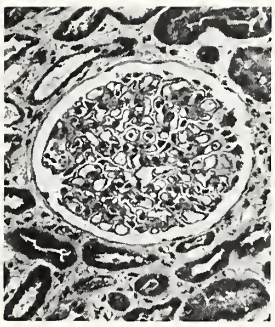


Figure 4

Renal biopsy showing tubular atrophy, basement membrane thickening, and interstitial edema.

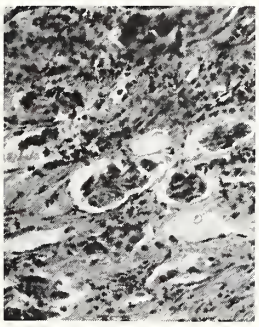


Figure 5

Bronchial wall biopsy showing nests of neoplastic cells.

elevation of the alpha-2 globulin fraction (figure 3). Urinalysis indicated a specific gravity of 1.020, and a 4-plus proteinuria. A few white blood cells and many granular hyaline casts were detected by examination of the sediment. No doubly refractile bodies were noted.

The admission electrocardiogram was within normal limits. The chest x ray film disclosed both a large amount of fluid in the right thoracic cavity, and a superior mediastinal mass (figure 1). A radioactive iodine uptake revealed 18 per cent uptake over 24 hours—this without demonstrable uptake over the superior mediastinal mass. A right thoracentesis yielded 1950 cc of clear yellow fluid. The specific gravity of this fluid was 1.014, and its total protein was 0.9 gm per 1,000 cc. A cell block preparation was negative for tumor cells, and a culture for *tubercle bacilli* was also negative.

During subsequent days the urine continued to show a 4-plus for protein, with quantitative determination of 20.9 gms per 100 cc. A urine electrophoresis revealed most of the protein to be albumin and alpha-1 globulin (figure 3). The Kahn test was negative, prothrombin first stage was 84 per cent, and alkaline phosphatase 8.8 units. Bleeding and clotting time platelet counts were normal.

Repeated lupus erythematosis preparations were negative. Examination of the urine for Bence-Jones protein was negative. A PSP determination showed six per cent excretion at 15 minutes, and a total of 47 per cent excreted after two hours. A throat culture confirmed a light growth of *beta hemolytic steptococci,* and a culture of a voided urine specimen cultivated *staphylococcus albus* which had a colony count of 50,000 per cc.

Venous pressure determination in the right femoral vein was 120 mm of water. A bone marrow study was interpreted as being mildly hypoactive, especially in the erythroid series. A pleural biopsy for tumor tissue was negative.

Diagnosis and Treatment

Since a definite relationship between the nephrotic syndrome and the mass causing the superior vena caval obstruction could not be established, a renal biopsy was performed. Marked thickening of the glomerular basement membranes was detected in the biopsy specimen. A fairly extreme interstitial edema was also noted. There were occasional lymphocytes and polymorphonuclear leukocytes, and the tubular epithelium showed somewhat severe vacuolation and fatty degeneration. These findings were in accord with the clinical diagnosis of renal vein thrombosis (figure 4).

A subsequent bronchoscopy demonstrated distortion and compression of the right lower lobe orifice. A biopsy of this area was therefore performed. These histological sections revealed edema of the bronchial wall. In addition, islands of pleomorphic cells having round to oval hyperchromic nuclei and abundant eosinophilic cytoplasm were also identified. Although these findings suggested a carcinoma in a bronchus—probably bronchogenic in type—this diagnosis could not be absolutely declared because the site of origin was not seen.

A review of the histological sections of a cervical lymph node which had been biopsied during the patient's first hospitalization in July, 1960, was made. This study showed many large follicular structures. Many of the cells present were of the reticulum cell type, and some of them were quite large. These findings were thought to represent lymphoma of the Hodgkin's type.

A therapeutic regime of low sodium, high caloric and high protein diet were instituted. About 50 gm of sodium-free intravenous albumin and 80 mg of Prednisone were administered daily for two weeks. In addition, an x ray program calculated to deliver a deep tumor dose of 2,000 r to the mediastinal lesion was initiated. Within eight days the patient showed marked improvement, and the intravenous albumin was discontinued. A total of 375 gm had been administered. Only a trace of edema remained in the arms. This was easily controlled by the occasional use of elastic dressings.

It should be noted that marked proteinuria persisted —15.2 gm per 1,000 cc of urine at the last estimation. However, a repeat serum electrophoresis revealed elevation of the total protein to 5.7 gm, with the albumin reaching 1.7 gm and A-2 globulin remaining quite elevated (figure 3). Subjectively, the patient claimed marked improvement.

Discussion

Increased pressure in the renal veins is an infrequent but well established cause of the nephrotic syndrome. It has also been acknowledged that increased renal vein pressure can cause a decrease in sodium and water excretion.[2] The nephrotic syndrome has been observed in cases of constrictive pericarditis, renal vein thrombosis, and chronic congestive heart failure.[1,4,7] In many such cases, subsequent reduction in the renal vein pressure was associated with abatement of the nephroses.

Acute renal vein thrombosis usually presents with flank pain, fever, a tender enlarging mass in the flank and transient microhematuria. Collateral circulation develops—particularly if the thrombosis is more gradual—and the nephrotic syndrome is likely to develop.

Renal vein thrombosis is often associated with thrombosis of other veins, particularly the inferior vena cava. However, renal thrombosis may also be seen in association with pre-existent disease of the kidney. Not infrequently, for example, renal thrombosis is seen in association with renal amyloidosis. Of 11 renal vein thrombosis cases reported by Harrison, Milne, and Steiner,[3] four also had amyloidosis of the kidneys. The diagnosis of renal vein thrombosis should be considered whenever the nephrotic syndrome is present—even if evidence of collateral venous circulation and flank pain are absent. In more obscure cases, the diagnosis may be established by renal biopsy.

In 1956 Pollak, et al,[6] reviewed the pathological features presented in seven cases of renal vein thrombosis. In all but one case the glomerular basement membrane was found to be thickened. Margination of leukocytes along the glomerular capillaries were observed in three instances. Tubular atrophy was a constant finding, while interstitial edema or fibrosis were noted inconstantly.

Glomerular basement membrane thickening, marked interstitial edema, and tubular atrophy out of proportion to the glomerular involvement was a finding in the renal biopsy specimen in our case. Pre-existent renal amyloidosis was suggested by the somewhat abnormal Congo Red test and the high Alpha-2 globulin fraction of the serum electrophoresis. This, however, was not substantiated by the biopsy specimen.

One final enigmatic point in this case concerns the fact that a patient with a serum albumin of 0.3 gm per cent may display massive edema of the upper extremities, but only a trace of edema in the legs. It is known, of course, that many factors contribute to edema formation. That a shift in oncotic pressure may occur in a patient without a concomitant shift in the level of serum proteins was aptly demonstrated by Armstrong, et al.[1] In addition to venous pressure and plasma protein abnormalities, another factor involved in edema formation is electrolyte aberration. Indeed, A. V. Wolf has asserted that the electrolytes—essentially sodium and electro-neutralizing anion—are by far the major constituents accounting for the extracellular or plasma osmality.[9]

As described previously, our patient initially suffered from massive edema of the legs. This edema subsided with long term steroid and diuretic management. It is postulated that the edema which involved the arms, neck, and face was caused principally by increased superior vena caval pressure and minor decrease in osmolality due to hypoalbuminemia, while sodium retention was effectively prevented by the diuretic agents. At the time of his present admission, the patient demonstrated no apparent

obstruction to venous flow in the inferior vena cava, although relative decrease may have been a contributory cause to the renal vein thrombosis. Thus, with proper diuresis, reduction of tumor mass by radiation, and intravenous infusion of albumin, the patient's edema was controlled.

Summary

The case history of a patient with the nephrotic syndrome secondary to renal vein thrombosis was presented. The possible relationships to an associated superior vena caval syndrome are discussed.

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The View Box

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Figure 1

This 60 year old man was admitted with a chief complaint of swelling and pain in his right 4th finger for about one month, which had increased in severity in the past week.

Physical examination revealed a chronically ill, emaciated man, with a blood pressure of 124/60. Dullness to percussion over the right chest with depressed breath sounds was elicited. The heart sounds were unremarkable. The liver was palpable two finger-breadths below the right costal margin. The right 4th finger was swollen and tender, and he had difficulty in using his right arm.

What is your diagnosis?
(1) Tuberculous dactylitis
(2) Enchondroma of the hand
(3) Metastatic tumor of hand
(4) Osteogenic sarcoma

(Continued on page 516)

The Radiology of Bone Tumors

Charles M. Nice, Jr., M.D., Ph.D.

Some of the more significant problems associated with the roentgenologic diagnosis of bone tumors are listed below:

1. Most bone tumors are relatively uncommon. Some are less common than others, while still others are quite rare.
2. Neoplasms of bone may be difficult to differentiate from inflammatory and other non-neoplastic tumoral affectations of bone.
3. Benign neoplasms may be difficult to differentiate from malignant neoplasms.
4. Primary malignant neoplasms may be difficult to differentiate from each other and also from metastatic neoplasms.
5. Tumors arising in unusual locations lead to difficulty in diagnosis.
6. Primary or metastatic malignant neoplasms may arise in bone which provided a previous site for benign conditions.
7. Constantly changing concepts concerning bone neoplasms lead to confusion in diagnosis and treatment.

The Value of Biopsy in Diagnosis

Most authorities do not question the value of biopsy in the diagnosis of bone tumors—despite the hypothesis that biopsy may aid in the spread of tumors. It is difficult to either prove or disprove this premise. Some malignant cells may certainly be found in the circulation before biopsy, yet demonstrable metastatic foci cannot be firmly established. On the other hand, unusual handling of a tumor—or excessive trauma during the biopsy procedure— may easily increase the number of circulating tumor cells. One could therefore maintain that excessive handling and trauma might probably facilitate the establishment of metastatic foci. In the last analysis, however, the value obtained from a properly performed biopsy far outweighs any possible risk that the biopsied tumor may give rise to metastatic activity.

The question often arises as to whether definitive treatment should be undertaken after a frozen section of biopsy has been studied. If the clinician, the radiologist, and the pathologist each has sufficient experience in bone tumor work, and if each cooperates with the other in the handling of individual patients, it is likely that most cases can be settled after the frozen section has been analyzed.

Differentiation of Neoplastic From Non-neoplastic Conditions

A Ewing's tumor of a long bone with periosteal lamellation is sometimes difficult to differentiate from pyogenic osteomyelitis. It is now known that reticulum cell sarcoma may also simulate pyogenic osteomyelitis.

A localized, purely osteolytic focus of osteomyelitis, which is centrally located near the end of a long bone, may occasionally simulate a benign cartilaginous tumor. Intracortical abscess and localized sclerozing osteitis of Garre are two conditions which may closely resemble osteoid osteoma, if the radiolucent nidus of the osteoma is not too clearly shown.

A subperiosteal hematoma, situated near the end of a long bone, may show an osteolytic area in the cortex with a reactive periosteal triangle (Codman) simulating osteogenic carcinoma. A subperiosteal hemorrhage in the iliac bone gives rise to the pseudotumor of hemophilia.

Radiation necrosis in the mandible, pelvis, or in the femoral neck may simulate osteolytic metastases. Usually, however, some irregular opacities produced by necrotic bone will identify the former.

Paget's disease may produce cortical strica-

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tions in a vertebral body. This condition sometime simulates hemangioma. In Paget's disease, however, there is a thickening of the cortex. The transverse processes may also be involved. Paget's disease of the pelvis may simulate osteoblastic metastases, but in most cases the thickened cortex and prominent trabecular pattern will indicate the probability of Paget's disease.

Another characteristic of Paget's disease is that there may be extensive change in either innominate bone—or in the sacrum—without apparent involvement of the other bones. Osteoblastic deposits are occasionally superimposed in Paget's disease. The osteoporosis circumscripta phase of Paget's disease may occur in a long bone as well as in the skull and may simulate osteolytic metastasis.

One patient had a roentgen diagnosis of hemangioma of the vertebral body with coarse vertical striations. At autopsy the bone showed replacement by fatty and fibrous tissue with no evidence of hemangioma. The solitary opaque or ivory vertebral body may be the site of Hodgkin's disease, osteoplastic metastases, or it may be idiopathic in nature.

Vertebra plana was formerly considered to be a form of osteochondritis or avascular necrosis but it is now recognized that it is usually due to eosinophilic granuloma, metastatic carcinoma or lymphoma.

Osteolytic metastases may be simulated by multiple osteolytic foci in the skull, mandible, spine, pelvis or long bones; by Han-Schüller-Christian disease; or by one of the other forms of histiocytosis X. These osteolytic areas are usually somewhat larger and perhaps a little more sharply marginated. Also, individual areas are more widely separated than is usually the case in metastatic tumor.

Villonodular synovitis may produce radiolucent areas on both sides of the hip joint which simulate metastases.[2]

Differentiation of Benign and Malignant Neoplasms

In benign tumors of bone the margins of the growth are usually more sharply demarcated and the cortex is intact. However, in some radiologic views the cortex may appear to be destroyed in some cases of giant cell tumor,[11] aneurysmal bone cyst,[24] chondroblastoma,[22] and in phantom or disappearing bone (Gorham's disease).[1,12] Giant cell tumors may be either benign or malignant. An irregularity of the margin or an apparent destruction of the cortex suggests the malignant variety. However, we have seen exception to this observation.

Enchondroma, chondroblastoma, and chondrosarcoma occur in the region of the epiphysis and metaphysis of long bones or flat bones and may expand the cortex. Usually there is an intact cortical margin in the first two conditions, and the cortex may be perforated in the latter. Nevertheless, at times the cortex is perforated in chondroblastoma, and it may appear intact in chondrosarcoma.

Differentiation of Primary Malignant Bone Tumors

In the usual osteogenic sarcoma which occurs eccentrically near the end of a long bone with variable degrees of osteolytic change and new bone formation, penetration of the cortex and periosteal reactive triangle (Codman) is quite characteristic. This is especially so if perpendicular spicules of bone extend into a soft tissue mass. In some cases, however, the tumor may appear more concentric, and periosteal lamellation may simulate Ewing's tumor reticulum cell sarcoma. In chondrosarcoma of the flat bones of the pelvis destruction of the cortex with production of a soft tissue mass may also occur. The calcification in chondrosarcoma may simulate new bone formation. Some designate the tumor as an osteochondrosarcoma if they detect cartilage cells and osteoid tissue microscopically. But for practical purposes this tumor should be considered an osteogenic sarcoma, since it has the more malignant prognosis of this tumor.

In recent years reticulum cell sarcoma has been separated from Ewing's tumor. The roentgen picture and cellular characteristics are similar but the reticulum cell sarcoma shows a reticulum stain and apparently has a little better prognosis following either surgical excision, roentgen therapy or both.

Both chondrosarcoma and fibrosarcoma may present as osteolytic areas surrounding an ill-defined slightly sclerotic margin either in the long bones or in the pelvis.

Both osteogenic sarcoma and chondrosar-

coma may arise in soft tissue adjoining a long bone or a phalanx, producing a soft tissue mass with calcific densities.

Differentiation of Primary and Metastatic Malignancy

Renal carcinoma may metastasize to long or to flat bones. Here it may produce an osteolytic lesion with expansion and destruction of the cortex to simulate a primary malignancy. Occasionally, lesions from the lung or gastro-intestinal tract metastasize to one end of a long bone, producing an osteolytic change with reactive bone or a periosteal reaction which simulates an osteogenic sarcoma. We observed one patient with a seminoma of the testicle which metastasized to the upper end of the humerus where it produced irregular osteolytic change and periosteal elevation which simulated osteogenic sarcoma. Neuroblastoma metastases may produce spicules of bone in the skull or long bones which simulate osteogenic sarcoma. Neuroblastoma metastases to the ilium produces reactive bone around the cortex simulating Ewing's tumor.

Myeloma may be solitary at first or it may be in multiple foci. Solitary deposits may expand bone, penetrate the cortex, and form a soft tissue mass. Since it is now well recognized that myeloma may produce reactive bone,[9] such a focus may simulate a primary osteogenic chondrosarcoma in the pelvis or ribs.

Unusual Locations of Bone Tumors

Some tumors present a characteristic roentgen picture when they occur in their most common locations. An enchondroma of a phalanx may be easy to recognize. So may a giant cell tumor in the epiphysis of a long bone in a patient in the 20-35 year age group, as may an osteogenic sarcoma occuring near one end of a shaft of a long bone. However, when a chondroma develops in the sternum, when a giant cell tumor arises in the sacrum, or when metastases occur in the distal long bones or phalanges, the roentgen appearance may not be quite so characteristic. Thus, differentiation from other tumors appearing in these regions may be difficult.

We observed one patient with a chondroma of the sternum which showed osteolytic change with calcific foci. A giant cell tumor of the sacrum may present as a relatively well circumscribed osteolytic process which may slightly expand the cortex and thereby be impossible to differentiate from aneurysmal bone cyst. In this connection it should be mentioned that while chordoma of the sacrum or clivus produces osteolytic changes and a soft tissue mass, it quite commonly also shows some calcification which differentiates it from the above tumors. Chordoma may rarely occur as an osteolytic focus in the body of a thoracic or lumbar vertebra.

Metastatic tumor is uncommon in the distal long bones and phalanges. The primary site is most frequently the lung. Occasionally this site may be in the gastro-intestinal tract, the kidney or the breast. The unusual location, osteolytic change, and destruction of the cortex may suggest a primary malignancy in some cases.

Changing Concepts

As more knowledge concerning the histologic characteristics and natural history of bone tumors is gained, various entities become newly recognized. Many tumors previously identified as giant cell tumors by histologic or roentgenologic methods may now be recognized as non-ossifying fibromata of the metaphysis, as aneurysmal bone cysts of the epiphysis or metaphysis,[5] or as reparative granulomata of the mandible.

Reticulum cell sarcoma has now been separated from Ewing's tumor, and chondroblastoma and chondromyxoid fibroma have been differentiated from chondrosarcoma.[14] Osteoblastoma, or giant osteoid osteoma, is now recognized as a benign tumor with osteoblasts. Multiple myeloma was formerly thought to be purely osteolytic, but is now recognized as having the ability to produce reactive bone.[9]

Malignant Tumors Arising in Previously Diseased Bone

A common diagnostic error may be found in cases where malignant tumors arise in previously diseased bone. Giant cell tumors or osteochondromata may be thought benign on initial biopsy or excision often recur later, and

show malignant characteristics. Multiple benign cartilaginous tumors or neurofibromatosis are two conditions in which one or more foci may develop malignant change with metastases.

Ultimately about five to seven per cent of patients with Paget's disease develop osteogenic sarcoma, chondrosarcoma, fibrosarcoma or a polymorphous sarcoma. Roughly 25 per cent of these will have multiple foci of malignant change.[8]

A draining sinus in a patient with osteomyelitis may develop an epipthelial malignancy which can directly invade the underlying bone. Patients with fibrous dysphasia may ultimately develop fibrosarcoma or chondrosarcoma.

Malignant processes sometimes occur following exposure to ionizing radiation. The occurrence of leukemia in persons exposed to the effects of nuclear explosion, and in radiologists who have been exposed to x rays for long periods is well known. A malignant change has been noted in some patients who have been irradiated for giant cell tumor. We have observed two patients who developed osteogenic sarcoma in pelvic bones approximately 12 years after irradiation therapy for carcinoma of the cervix. An internist who fluoroscoped patients for many years without using leaded gloves developed epithelial carcinoma of the phalanges which invaded the bone.

Rare Tumors of Bone

Some tumors cause difficutly in diagnosis because of relative or extreme rarity. Cystic angiomatosis,[13] multiple lymphangiectasis,[4] and lymphangioma[25] of bone may present with multiple radioluscent areas in the long bones, skull or vertebrae. Hemangioendothelioma[6] or angiosarcoma may also cause similar changes. Synovioma may occur near a joint or arise outside of the joint area, forming a soft tissue mass, sometimes with calcification, and sometimes destroying adjacent bone.[23] Although it rarely metastasizes to other bones, we have seen one case which metastasized to the upper humerus.

Adamantinoma usually occurs in the mandible, but, occasionally it occurs in the labia, where it produces relatively well localized osteolytic and reactive changes. These changes, however, may ultimately show pulmonary metastases. Adamantinoma has also been reported in the capitate bone.[7]

Rarely a bone tumor appears to arise within the cortex of a long bone. Jaffe has reported intracortical osteogenic sarcoma.[15] We observed one patient who had neurofibromata apparently arising in the cortex of a long bone.

Arteriography in Bone Tumors

Sutton[28] and Lagerman, Lindbom et-al[16-19] have contributed much recent data concerning the value of arteriography in tumors of bone and soft tissues in the extremities. In general, tumors with a high grade of malignancy almost always show increased vascularity, whereas tumors of low grade malignancy (such as grade I fibrosarcoma), frankly benign tumors, and inflammations show a normal or only slightly increased vascularity. The authorities cited above and we have encountered definite exceptions to this general rule. We have seen several instances of increased vascularity in inflammatory lesions. Sutton also cites cases in which increased vascularity was demonstrated around a thrombosed popliteal aneurysm and also around a renal abscess. In both instances, the increased vascularity suggested the presence of malignancy.

Hypertrophied feeding vessels have been shown in Paget's disease and hypertrophic pulmonary osteoarthropathy. Increased vascularity is seen in relation to varicose ulcers in the leg. Angiomatous malformations demonstrate increased vascularity so as to resemble a highly malignant tumor.

Benign tumors in various parts of the body may show pathological circulation. These include meningioma, hemangioblastoma, parathyroid tumors, glomus jugulare tumors, carotid body tumors, pheochromocytoma, and uterine fibroids. In osteoid osteoma the nidus and surrounding tissue show increased vascularity which may be of value in differentiating this tumor from intracortical abscess or localized sclerosing osteitis.[18]

Giant cell tumors reveal variable degrees of increased vascularity and pooling of contrast in the tumor. Whether this variability is related to the degree of malignancy has not been determined. Arteriography aids in defining the extent of the tumor when it extends through the cortex.



Figure 1
Aneurysmal bone cyst.



Figure 2
Early arterial phase of arteriogram in patient of Fig. 1.



Figure 3
Late arterial phase, pooling of contrast and early venous filling.



Figure 4
Same patient as Fig. 1-3 two months after perfusion with nitrogen mustard.

In osteogenic sarcoma the degree of increased vascularity varies with the degrce of malignancy. The vascularity is greatly increased in highly osteolytic tumors. In osteoblastic tumors some vascular parts may be shown. Osteoblastic tumors with little osteolysis and juxtacortical osteogenic sarcomas may be only slightly more vascular than the surrounding tissue.[17]

In chondrosarcoma the degree of hypervascularity also varies with the degree of malignancy.[16] The vascular pattern in tumors of low vascularity may indicate the best site for biopsy. Chondromas are non-vascular.

Fibrosarcomas also show increased vascularity correlated with degree of malignancy.[28] Synoviomas have increased vascularity. Chordomas are non-vascular. Metastatic tumors show variable increase in vascularity. The osteolytic type of renal and thyroid tumors are usually more vascular. Metastases from the lung and breast may or may not show vascularity. Myeloma deposits may show a slight generalized opacification.

Eosinophilic granuloma, fibrous dysphasia and lipomas do not shown vascularity. Aneurysmal bone cysts show hypertrophied feeding vessels, pooling of contrast within the cyst and early filling of the draining veins. The early venous filling is usually less than in highly malignant tumors.[19]

When chemotherapeutic perfusion of tumors is indicated, angiography helps the operator to be certain that the injection is being made into vessels feeding the tumor (See Figures 1-4).

Arteriography is also of value in attempting to ascertain whether malignant change has occurred in bone or surrounding tissue when a previous disease has been present. One patient we observed with polyostotic fibrous dysplasia had pain related to a tibial lesion which looked more osteolytic on the plain roentgenogram. Arteriography showed increased vascularity and biopsy revealed fibrosarcoma. Another patient with neurofibromatosis had a sclerotic lesion in the upper tibia and developed pain and swelling in this area. Arteriography showed increased vascularity in the soft tissue around the bone lesion. Biopsy of the bone revealed benign tissue, but biopsy of the overlying soft tissue revealed neurofibrosarcoma.

It appears then, that in properly selected cases the use of arteriography may be of significant value in the study of tumors of the bones and soft tissues.

Summary and Conclusions

The radiology of bone tumors presents many challenges in the differentiation of malignant and benign types of conditions.

Arteriography in selected cases may be of value in questionable diagnosis, in demonstrating malignancy in previously diseased bone and in chemotheraphy by perfusion.

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The View Box

—diagnosis and discussion *(Continued from page 509)*

Diagnosis: Metastasis from a carcinoma of the lung to the hand.



Figure II

Bronchogenic carcinoma is the most frequent invader of the hand, and often the metastasis is the first indication that there is a tumor in the lung. The lesions are believed to be blood borne.

Roentgenologically, the principal finding is an osteolytic lesion involving one or more of the tubular bones of the hand and sparing the adjacent joints. The carpals are rarely involved. Metastasis below the knees and elbows are rare but do occur.

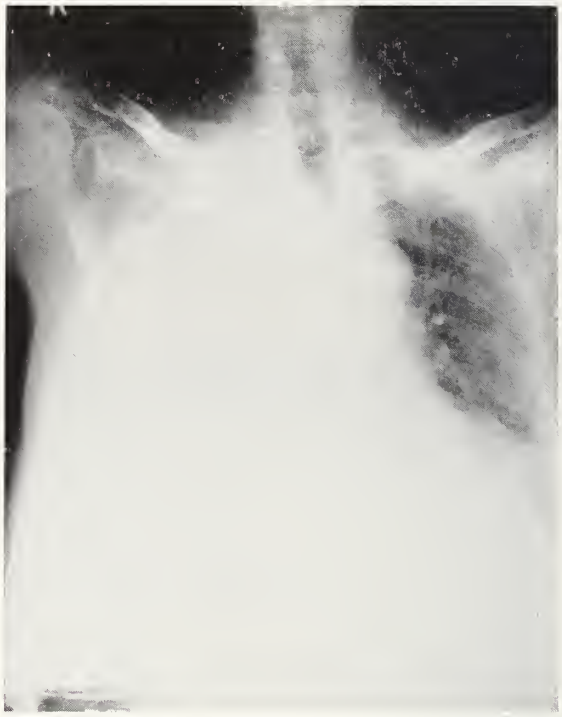


Figure III

The destructive lesion in the lateral epicondyle of the humerus is a second metastatic deposit. The patient had a bronchogenic carcinoma with massive pleural effusion.

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Detection of the Curable Hypertensive Patient

Atif Saad, M.D.

In itself, hypertension is not a disease. Rather, it is a physical sign, just as fever is a physical sign. Yet, every medical practitioner knows that a state of hypertension can lead to any number of different pathological conditions because of its possible deleterious effects on the cardiovascular-renal system. It is therefore imperative that the etiology of each hypertensive condition be identified and removed—just as the cause of every fever must be identified and removed.

Every physician is also aware of the fact that the etiologies of some hypertensive conditions are difficult—if not impossible—to determine. On the other hand, the specific causes of certain other hypertensive states are clearly defined. These lend themselves to clear-cut, positive diagnoses.

Essential Hypertension

In practice, the term "essential hypertension" is generally used to designate a hypertensive state of unknown etiology. The phrase indicates our basic inability to adequately understand or explain the complex phenomena which tend to produce an elevated blood pressure in certain individuals. An estimated 85 to 90 per cent of all hypertensive cases fall into the "essential" category.

There is sufficient evidence to suggest that nervous vasoconstrictor influences produce the primary etiological factors which are responsible for the development of essential hypertension. Other evidence indicates that heredity —through genetic disposition—may be capable of playing a significant role in predisposing the condition.

Most patients who suffer from essential hypertension are treated by trial and error—invariably with drugs.

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Other Conditions Linked to Hypertension

It is well known that a wide variety of readily-diagnosed pathological conditions are, in one way or another, associated with blood pressure elevation. Such conditions do not present the appreciable diagnostic problems that essential hypertension does. For example, thyrotoxicosis, A-V fistula, anemia, brain tumor, pituitary tumor (acromegaly), coarctation of the aorta, polycythemia, eclampsia, and Cushing's disease may be easily diagnosed by means of proper physical examination and pertinent laboratory tests.

A small group of curable hypertensive conditions may, however, present genuine diagnostic challenges. Included in this group are pathological entities such as primary aldosteronism, pheochromocytoma, and unilateral kidney disease (vascular, obstructive or parenchymatous). All cases involving these conditions should first of all be differentiated from those associated with essential hypertension. Next, they should be distinguished from hypertensive states which are positively linked to bilateral kidney disease due to glomerulonephritis, pyelonephritis, collagen disease or amyloidosis.

Clearly, some reliable diagnostic screening system must be available to the physician if he is to successfully pin-point the specific etiology of any given case of hypertension. The purpose of this paper is to report on just such a system. We believe that the routine *hypertensive work-up* to be described here is sufficiently thorough to screen out almost all curable hypertensive conditions.

The Hypertensive Work-up

The hypertensive work-up used on our medical service is based on six procedures. These are: (1) A complete history, (2) a physical

examination, (3) pertinent laboratory tests, (4) X-ray studies, (5) EKGs, and (6) pharmacologic tests for pheochromocytoma.

The History

A complete history should provide answers to questions such as these:

1. At what age was the hypertensive state first detected in the patient?
2. Is there a positive family history that might suggest a diagnosis of essential hypertension? A negative family history is a fairly strong point that might be used to rule against such a diagnosis.
3. Has the hypertension been paroxysmal or sustained? Also, has it been associated with hot flashes? If so, a diagnosis of pheochromocytoma is likely.
4. Did the hypertension follow an episode of flank pain? This intimates renal infarction.
5. Did the hypertension become accelerated recently? This suggests renal artery disease.
6. Is there any history of muscle weakness or recurrent paralysis, tetany, polyuria and polydipsia? Any of these suggests aldosteronism.
7. Is there a history of prostatism, urinary symptoms, fever, chills, costo-vertebral angle pain or tenderness, or are there multiple pregnancies? If so, polynephritis is intimated.
8. Has the patient had a history of eclampsia or glomerulonephritis?
9. Has the patient had intermittent fever, pleurisy, pericarditis, arthritis, or skin manifestations? These suggest collagen disease.
10. Does the patient have a chronic condition such as bronchiectasis, ulcerative colitis, regional enteritis or lymphoma? This indicates the possibility of amyloidosis.

The Physical Examination

The blood pressure should be recorded in both arms. Readings should be taken in both the supine and the standing positions, and on different occasions in order to establish a reliable base line.

A blood pressure drop in the erect position indicates a renal or adrenal etiology of the hypertensive state. An elevation does not exclude the above mentioned diagnosis, but it does favor one of essential hypertension.

Examination of the fundi and of the peripheral pulsations is of primary importance.

Laboratory Studies

The following laboratory studies should be made in the hypertensive work-up:

1. A complete blood count.
2. Urinalysis: At least two or three midstream specimens should be examined. A quantitative urine culture is imperative if polynephritis is suspected.
3. Serum potassium and CO_2: Hypokalemic alkalosis is a characteristic picture of primary aldosteronism. A potassium level below 3.0 and a CO_2 combining power of more than 33 meq per liter will suggest this diagnosis.

The urine reaction is usually neutral or alkaline. An isolated low potassium could be produced by the administration of diuretics. A normal serum potassium and CO_2 combining power, on the other hand, practically rule out a dignosis of primary aldosteronism.

4. Fasting blood sugar and blood urea nitrogen.
5. The renal functional status should be assessed by means of these preliminary tests:
   a. The phenolsulfonphthalein excretion test.
   b. The urea clearance test.
   c. The 12-hour concentration test. This test should not be attempted in the presence of an elevated BUN because of its possible harmful effects.

X-ray Examination

An *intravenous pyelogram* is essential. Particularly sought are evidences of pyelonephritis, obstruction, congenital abnormalities, kidney tumor or an extra renal tumor impending upon the kidney, and disparity in the function of the kidneys. Occasionally a severe lesion of the renal artery may be detected by the I.V.P. The I.V.P. should not be attempted if the BUN level is above 35 mg per 100 ml because of inadequate dye excretion and poor visualization.

Retrograde pyelography may be done as an alternative to the I.V.P. if the latter is not successful. It may also be done in addition to the I.V.P. if more information is necessary or desired.

The *renogram* is now being used instead of

the I.V.P. in some centers. This is because the renogram is thought to provide more exacting information about renal arterial status.

The EKG

EKGs are done to determine the presence of left ventricular hypertrophy or of hypokalemia.

Pharmacologic Tests For Phenochromocytoma

Although various different drugs have been tried in making pharmacologic tests for phochromocytoma, histamine and phentolamine remain as the most commonly used agents in this instance.

As basal blood pressure reading of 170/110 has been designated as a dividing line. The histamine (provocative) test is used if the reading is below the dividing line value—the phentolamine (blocking) test is used whenever the reading is above the dividing line value.

The Histamine Test: It should be noted that Roth[2] stresses the cold pressor test as a prerequisite for the histamine test unless the diastolic blood pressure is above 150 mm mercury. The procedure is as follows:

A basal blood pressure reading is obtained, and the patient is made to lie down. After he has rested comfortably, one hand is immersed up to the wrist for one minute in water at 4° C. During this minute the blood pressure in the other arm is measured at 15, 30, and 60 seconds consecutively. The maximum blood pressure reading taken during this period of painful stimulation is recorded. Immediately after the blood pressure returns to basal level, 0.05 mg of histamine in 0.5 ml of normal saline solution is injected intravenously. A blood pressure reading is taken every 30 seconds.

The blood pressure always drops soon after histamine administration, but it increases rapidly thereafter, attaining a maximum level within two minutes. If a pheochromocytoma is present, the blood pressure rises well above the cold pressor level, and a "simulated" clinical picture of the attack appears. Five mg of phentolamine should be ready for immediate intravenous injection if the blood pressure becomes alarmingly high during the attack. Such an injection causes the blood pressure to drop, and the manifestations of the attack disappear within one minute after the phentolamine injection is made.

If essential hypertension is present, the blood pressure does not rise above the cold pressor level following histamine injection, and the clinical picture of the attack does not appear.

The Phentolamine (Rigitine) Test: A basal blood pressure of more than 170/110 should drop—by at least 35/22 mm of mercury—within three to four minutes following an injection of five mg of phentolamine if pheochromocytoma is present. This dropped reading returns to its previous basal level within 10 to 15 minutes.

Precautions: Four precautions should be taken before either test is started to avoid having false negative or false positive results. These precautions are:

1. A reliable blood pressure reading should be obtained by repeated recordings while the patient is lying down comfortably for one-half hour.

2. The blood pressure should be taken in both arms to detect any disparity.

3. The blood pressure changes should be observed quickly during the test as the timing is very precise.

4. The patient should not have taken any sedatives or narcotics for at least 48 hours, and he should not have had any antihypertensive drugs for at least eight to 10 days. Any of these substances can produce possible false positive and false negative results. Moyer[3] and other authorities recommend discontinuation of chlorthiazide and hydrochlorthyazide for one week, and serpasil and guanethidine for two or three weeks before performing these tests.

Confirmatory Procedures

Thus far, the routine work-up for practically every hypertensive has been outlined. Certain positive results, however, may necessitate further confirmatory procedures or investigations. For example, certain tests should be performed if either the phentolamine or the histamine tests are positive. These tests should also be performed in any situation where the phentolamine or the histamine tests cannot be performed because the patient is, or has been, receiving drugs. These tests are:

1. *Determination of the plasma pressor*

amines (epinephrine-like substances): Roth,[2] reporting a series of 49 patients without pheochromocytoma, found the normal mean value of plasma pressor amines to be 2.5 mcg per liter of plasma, with a range of 0.75 to 5.5 mcg per liter. In 56 patients with pheochromocytoma, the range was 6.9 mcg per liter.

A false negative test may be obtained between paroxysms. If pheochromocytoms is present, however, the test should become positive during the histamine test. Axotemia, jaundice, and lymphoblastoma may give a false positive test due to the presence of fluorescent substances other than pressor amines. A false positive test may also be produced by Furadantin, Tetracycline, and many vasoconstrictors—including those incorporated in many nose drops.

2. *Determination of urinary cathecholamines:* In 287 patients without pheochromocytoma, also reported by Roth, the average total cathecholamines was 9.4 mcg per 100 ml. The average 24-hour output was 115 mcg. In four cases of pheochromocytoma, the range was 42 to 2,649 mcg per 100 ml 30 minutes after the injection of histamine. Here again, the level between paroxysms may be normal. Nasal drops (vasoconstrictors) and bananas may produce a false positive result.

3. *Colorimetric test for pheochromocytoma:* Gitlaw[4] described a simple rapid colorimetric test for pheochromocytoma where a metabolite of norepinephrine and epinephrine (VMA) is determined quantitatively in a fasting urine specimen after abstaining from medications, coffee, fruits, and vanilla-containing substances for 48 hours. The author claims this test may be positive even during the normotensive state if a pheochromocytoma is present, and that a negative test needs no further studies. A positive test, however, needs further confirmation by the other known diagnostic tests.

If a diagnosis of primary aldosteronism is suspected, because of a refractory hypokalemic alkalosis, the 24-hour urine excretion of aldosterone should be determined. The normal value is five to 15 mcg. An appreciably elevated level confirms the diagnosis, especially in the absence of conditions that can produce secondary increase in aldosterone excretion. These conditions include congestive heart failure, liver cirrhosis with ascites, and edema secondary to renal disease. In a case of a malignant aldosterone-secreting tumor seen in this hospital, the 24-hour urine aldosterone secretion was 57 mcg.

Three possible tests are indicated in cases of hypertension of renal origin. They are:

1. *Kidney biopsy:* This procedure is indicated if a parenchymatous kidney disease is suspected and if the exact nature of the underlying lesion has not been determined. According to reports from different sources,[5,6] a needle kidney biopsy using the Vim-Silverman needle is a simple, rather atraumatic, and very informative procedure. There are no major complications if it is done while the patient is in the prone position, and there are no contraindications such as bleeding tendency, solitary kidney, renal nephrosis, renal tuberculosis, and uncooperative patient.

2. *The diodrast uptake and clearance test:* This test has been used to detect an abnormal kidney function. It has also been used to detect an underlying kidney disease in hypertensive patients. Recently, radioactive iodine (labeled "Diodrast") has been used with external monitoring over the renal areas as a screening test for unilateral kidney disease. The test takes a short time, but requires special apparatus and skilled personnel. In a series of 150 patients on whom this test was performed by Smithwick,[7] there were no false negative results. This test, however, does not detect the nature of the underlying kidney lesion.

3. *The Howard test:* Bilateral uretheral catheters are introduced and the urine dollected. The test is considered to be positive if the urine volume is reduced by at least 50 per cent, and the sodium content by at least 15 per cent on one side. To obtain a reliable result, these four precautions should be taken:

a. Adequate hydration: An intravenous infusion of five per cent dextrose in water should be started two hours prior to the test and run at the rate of 500 ml per hour.

b. Adequate intake of sodium chloride prior to the test to insure adequate urinary sodium content.

c. Adequate sedation during the test.

d. The urethral catheters used must fit well so that no leakage around the catheters occurs.

The value of the Howard test has been a sub-

ject of controversy. Smithwick[7] claims that the diagnosis of hypertension of unilateral renal origin can be made if the Howard test is positive. He adds that no other diagnostic procedure, such as abdominal aortography, is necessary unless the test is unsatisfactory or unless unilateral renal hypertension is highly suspected and the test has been negative.

Yendt[8] reported 125 hypertensive patients on whom the Howard test was performed. Confirmatory evidence for renal ischemia was present in 20 patients who had a positive Howard test, and who were operated on. Yendt considers renal aortography too hazardous a procedure (unless performed by experts) to be used as a screening test, and that it should be cut to a minimum by the use of the Howard test. However, he still recommends aortography as a confirmatory procedure for renal artery disease whenever the Howard test is positive (a renal artery lesion in a young person is amenable to plastic surgery), and in the occasional patient who presents a clinical picture that strongly suggests this possibility despite a normal Howard test.

Poutasse,[9] Dustan,[10] and Page[11] claim two pitfalls for the Howard test. First, a lesion involving a segmental branch of the renal artery may not change the renal sodium handling of the kidney. This may not be detected by the Howard test even though it could be associated with the severe hypertension that remits following nephrectomy. Second, the Howard test could be positive in patients with bilateral renal arterial disease, where uninephrectomy would be foolhardy.

These authors say, however, that since aortography is not readily available to all physicians, the Howard test can prove valuable as a screening test for renal artery disease. Thus, those patients with disparity of renal functions which warrant further investigation by renal aortography can be indicated. On the other hand, they deny any major complications in about 500 abdominal aortographies they have done. They stress this procedure as the most important means of recognizing renal artery disease. They have been using aortography as a routine on hypertensive patients falling into the following groups:

1. Those that have disparity in the excretory function of the two kidneys as shown by the intravenous pyelogram or a difference of one cm or more in length.
2. Patients under the age of 35.
3. Elderly patients whose hypertension is of recent onset.
4. Those patients of any age with long-standing hypertension which abruptly becomes severe.
5. Patients with malignant hypertension arising without a preliminary period of essential hypertension.
6. Patients with hypertension following an episode of flank pain.

DeBakey, et al,[12] go even further, claiming that hypertension (moderate or severe) as such may be an indication for aortography. They report the occurence of renal arterial disease in 30 per cent of all their hypertensive patients and deny any important complications in 1800 renal arteriographies they have done.

Summary

Any hypertensive state should be investigated for the possibility of a curable etiologic agent before treatment is initiated. The routine hypertensive work-up should follow the pattern described in this paper.

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Genito-Urinary Tuberculosis

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The incidence of genito-urinary tuberculosis parallels the incidence of pulmonary tuberculosis. A study of vital statistics indicates a steady decline in both the rate of new active cases and the death rate since the turn of the century. The declines in the first half of the century were due, in part, to improved case finding and care of tuberculous patients. Lowered rates reflect improvement in general living standards. Precipitous drops in the rates occurred in 1947 when potent antituberculosis therapies became available. However, a substantial human reservoir of tuberculosis persists. For this reason, tuberculosis studies should be included in the investigation of any chronic or recurrent urinary infection which has resisted the usual antimicrobial drugs.

Medical Treatment of Genito-urinary Tuberculosis

Modern antituberculous drug therapy can cure genito-urinary tuberculosis. There is no intended inference here, however, that all genito-urinary tuberculosis can be cured medically. Any medication may be of little benefit to far-advanced cases because irreversible processes have set in. Inadequate vascularity to chronic lesions, for example, precludes their saturation with therapeutic levels of a given medication. Avascular tuberculous granulomas or tuberculosis pyonephrosis may harbor virulent tubercle bacilli which remain as a constant threat to the patient's health.

Relative to the medical treatment of genito-urinary tuberculosis one must be aware that some strains of the tubercle bacillus are resistant to—or can become resistant to—the usual drugs. In such cases more exotic, and usually more toxic, preparations must be administered. Reports indicate that an alarming number of drug resistant tubercle bacilli are being isolated from patients who have had no previous therapy. This implies that there is a growing reservoir of drug resistant tubercle bacilli. Specifically, one may mention reports from New York indicating that eight per cent of tubercle bacilli are resistant to one or more of the commonly used drugs; the incidence from Europe is about 19 per cent; a recent report from Virginia records 44 per cent resistant strains in new cases, and 67 per cent resistant strains in old cases of tuberculosis.

There should be no complacency regarding the importance of chronic or recurrent, specific or nonspecific, infections of the urinary tract. The physician should not blindly treat infection of the urinary tract with toxic and occasionally lethal medications. Continued medical treatment of genito-urinary infection which is medically incurable by virtue of concomitant genito-urinary disease is ill-advised. Every urologist is mindful of complicating factors such as stasis, foreign body, tumor, and distorted urologic physiology. None of these conditions lends itself to successful medical management of genito-urinary infection. Still another complicating factor is the kind of tuberculosis which resists conventional antibacterial medication.

The diagnosis of genito-urinary tuberculosis cannot be established without animal inoculation and/or cultural study. Many types of acid-fast bacteria which are not tubercle bacilli exist in nature. These so-called *Anonymous mycobacteria* and the *Nocardia asteroides* may be mistaken for tubercle bacilli in a microscopic study. Ordinary care is necessary in the collection of urine specimens for study to minimize contamination.

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Discussion

A review of 60 patients with genito-urinary tuberculosis who have come to our attention during the past three years has revealed the following facts:

(1) Very few of the patients had active pulmonary tuberculosis, and in no case was surgery postponed because of lung pathology.

(2) Calcification in the renal parenchyma or calculus disease in the renal pelvis complicated six cases.

(3) Calculus disease may cause delay in the proper identification of the tubercle bacillus as the cause of concurrent infection.

More than half of the patients we studied had secondary infection. In some cases, the secondary infection was treated for too long an interval before the proper specific nature of the disease was established.

Persistent or recurrent genito-urinary infection calls for repeated urologic surveys. Tuberculous studies should always be included in the routine. Minimal lesions may be recognized on later pyelograms, but only repetition of pyelograms which have a high index of excellent diagnostic quality will suffice. Perhaps it is in this minimal renal involvement that most success in searching out early genito-urinary tuberculosis will lie. Figure 1 is an x-ray film of a patient who was treated for urinary infection for three years before the urine cultures were found to be positive for tuberculosis, and cavitation was recognized in the region of the middle calyx on the right.

Contrast the previous patient with the patient whose pyelogram is demonstrated in figure 2. This patient had three miserable, debilitating episodes of urinary sepsis before the pyelogram was taken. A far advanced renal tuberculosis was found. Nephrectomy was performed after the preliminary antituberculous medications. Nothing would be left to save following the extensive sclerosis that would follow prolonged medical therapy in the confines of the sanitorium.

Corrective surgery is occasionally required to



Figure 1
Middle Calyx on the right shows early cavitation caused by tuberculosis.

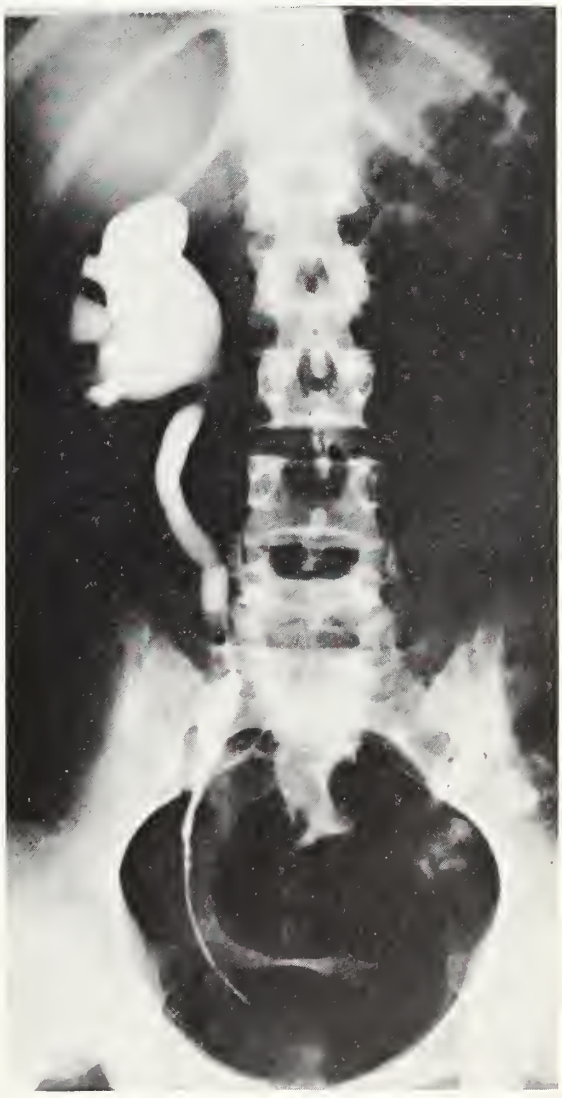


Figure 2
Retrograde pyelogram demonstrates far advanced renal tuberculosis.



Figure 3
A cavity is noted at the upper pole of the kidney. The deformity resulted with healing of renal tuberculosis.

preserve renal parenchyma after the tuberculosis is resolved. Figure 3 demonstrates a persistent cavity in the upper part of the kidney which was caused by tuberculosis. Hemine-phrectomy removed the residues of pathology, the urine became normal, and the patient was restored to health.

Another interesting clinical entity in this group was a 64-year-old white male who was admitted to the hospital for perineal biopsy for suspect carcinoma of the prostate gland. The biopsy tissues were reported as tuberculous. The nodular prostatic tissues resolved when the appropriate antituberculous mediations were started.

The last brief report is the case of a 68-year-old, white female who was admitted to the hospital for study of a persistent urinary tract infection. Acid-fast bacilli were found in the stained urine sediment, but culture studies disclosed that this bacillus was a Skotochromogen organism. The cause of the persistent infection was a stricture of the ureter which responded to instrumental therapy. This patient was spared two years of antituberculous medications.

Summary

Basic facts concerning the incidence of tuberculosis are given. Pitfalls in the diagnosis of genito-urinary tuberculosis have been emphasized. A plea is made for continued diligence in searching out genito-urinary tuberculosis among those patients having chronic or recurrent urinary infection.

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(See page 558 in this issue)

Culdocentesis—a Useful Diagnostic Aid

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Culdocentesis is an easy and safe diagnostic procedure which can shorten physician delay in the definitive treatment of the patient with an acute abdomen. Inspection of material obstained from needle aspiration of the cul-de-sac will on most occasions distinguish the medical from the surgical problem. Needless exploratory surgery will thereby be avoided, and definitive therapy instituted. Conditions such as obesity and guarding from pelvic pain may obscure physical findings which ordinarily would be diagnostic.

Culdocentesis may be performed in the office. It can make the diagnosis in such cases and might prevent unnecessary hospitalization or tragic delay. It has been repeatedly demonstrated that liberal use of culdocentesis has uniformly reduced loss of life and need for whole blood replacement.[6,7,22]

The major indication for culdocentesis undoubtedly is in suspected ectopic pregnancy. Its usefulness in establishing this diagnosis has received much attention in the medical literature. We have been impressed that in conditions other than ectopic pregnancies, the material aspirated is often typical enough to be diagnostic.

Technique

1. After pre-medication the patient is placed in lithotomy or slight Fowler's position.
2. A bimanual examination is done to check the position of the uterus and to confirm previous findings.
3. With the cervix and posterior fornix exposed with a speculum, the vagina is prepared with an antiseptic solution.
4. The posterior lip of the cervix is grasped with a tenaculum and traction is applied.
5. A large gauge spinal needle is inserted through the vagina and into the peritoneal cavity at a point in the midline 1 cm posterior to the reflection of the vaginal mucosa off the cervix.
6. A 20 cc syringe containing 5 cc of air is attached to the needle. The air is injected to determine penetration of peritoneal cavity.
7. The cul-de-sac is aspirated while slowly withdrawing the needle and the material obtained examined carefully.
8. If this first attempt is unsuccessful, the tap should be repeated.

Differential Diagnosis

A variety of materials may be obtained and all must be evaluated carefully. Occasionally no material is aspirated. A *dry tap* is not considered either a positive or a negative result and is of no diagnostic help. The procedure should be repeated. A few cc of clear peritoneal fluid indicates a *negative tap*. A greater volume of clear fluid may be obtained after rupture of a physiologic cyst of the ovary.

A culdocentesis is considered to be a *positive tap* when non-clotting blood or some other diagnostic material is obtained. Blood which clots on standing usually comes from a pelvic vein. It may, however, occur in massive hemorrhage if the blood is aspirated before clotting.

Non-clotting blood containing small clots or flecks of fibrin signifies intraperitoneal hemorrhage. The hemorrhage may be from a ruptured ectopic pregnancy, tubal abortion, bleeding corpus luteum cyst, spontaneous uterine rupture, or traumatic uterine rupture. On occasion an unsuspected source of hemorrhage such as ruptured spleen or liver has been found. The presence of small clots is of great sig-

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nificance. They may cling to the sides of the syringe as it is tilted or they may be seen after spreading the blood on a gauze pad.

Sero-sanguinous fluid is frequently encountered. The fluid may be cloudy or turbid and blood tinged. It is obtained in pelvic inflammatory disease and other forms of peritonitis, perforated viscus, and carcinomatosis. A microscopic examination for bacteria, pus cells, or malignant cells is helpful. This material may be submitted for culture or further cytologic study. If there is considerable blood in the fluid, it may be difficult to distinguish from peritoneal hemorrhage. A sample spun down in a hematocrit tube will have a packed cell volume of less than five per cent.

Bloody purulent material may be aspirated after rupture of a tubo-ovarian abscess. This material should also be examined microscopically and then submitted for culture and antibiotic sensitivity studies.

A pelvic abscess produces frank *yellow pus*. A culdocentesis should always be done prior to colpotomy for drainage of a pelvic abscess. It can on occasion be done in the examining room. The drainage can then be scheduled and done at a time when other cases will not be contaminated.

Dark hemolyzed blood contained in an endometrioma or in a hematocele surrounding a chronic ectopic may be obtained.

Some unusual materials have been obtained and are very characteristic. A mucinous material produced in a pseudomyxoma peritonaei or a ruptured pseudomucinous cyst has been obtained. This type of material may also be occasionally produced by a disseminated abdominal carcinoma.

A ruptured or leaking cystic teratoma produces violent peritoneal irritation. Oily *sebaceous material* when obtained on culdocenteses is diagnostic. If examined closely it may contain small, fine hairs.

An unusual milky fluid was aspirated on one occasion. Microscopic examination showed squamous cells and lanugo hairs and proved this to be *amniotic fluid* from an abdominal pregnancy.

Discussion

A review of the modern literature reveals numerous articles, usually concerning ectopic pregnancies, in which culdocentesis is considered. A debate frequently follows which compares the merits of this procedure with culdoscopy, posterior colpotomy, or clinical appraisal alone in the diagnosis of ectopic pregnancy.[3,9,14,17] Culdocentesis should in no way replace a careful history and clinical evaluation of the patient, nor should it be considered competitive with other diagnostic techniques, such as colpotomy or culdoscopy. We feel that the differences of opinion arise from misunderstanding as to the proper place, technique and interpretation of results with culdocentesis.

A frequent criticism has been the percentage of false negative aspirations. The erroneous inclusion of a dry tap in this category accounts for the majority of "false negatives."[17]

A few cc of normal peritoneal fluid must be obtained to warrant the diagnosis of negative tap. Fifteen to twenty degrees of Fowler's position will cause whatever peritoneal fluid is present to pool in the cul-de-sac of Douglas.

The number of dry taps will be further diminished by a simple test of penetration of the peritoneal cavity. Lack of resistance of injection of air indicates proper placement of the needle. Resistance to injection will be encountered until the needle is within the cul-de-sac.

A negative tap should not lull the clinician into a false sense of security, but it does preclude the need for emergency laparotomy.

Any material other than normal peritoneal fluid that is obtained should not be discarded before definitive diagnosis is established. Culture, microscopic examination or chemical analysis may be an aid to therapy.

A review of the medical literature fails to reveal any reported complications from culdocentesis. The theoretical danger of puncture of the bowel or blood vessels can be minimized by strict adherence to the described technique. Many reports include aspiration of fecal material on rare occasions. Even this event has failed to result in abscess, peritonitis, fistula, or febrile morbidity. It should be emphasized that the point of the needle should be kept in the mid line and not wandered laterally.

Summary

Culdocentesis rates a prominent place in the approach to the patient with an acute abdomen

in whieh ectopic pregnancy is a possibility. This rapid, safe, easy technique is readily available to the physician in almost any situation. If the results of this simple procedure are equivocal, one may proceed with more elaborate diagnostic techniques.

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Jaundice and Sheehan's Syndrome with Toxemia of Pregnancy

Thomas J. Fitzpatrick, M.D. and Vincent S. DiGiulio, M.D., *Joliet, Illinois*

The case reported here is one of late pregnancy that was complicated by jaundice and by the appearance of multiple endocrinopathies (Sheehan's Syndrome) within the post-partum period in a severely toxemic patient with poorly controlled fulminating eclampsia without convulsions. Sheehan's syndrome, which is usually considered to follow severe post partum hemorrhage and pituitary necrosis, has been reported by Sheehan to follow severe toxemia.[1]

Case Report

This 33-year-old Para 2, Grav. 3, was admitted to St. Joseph Hospital on 10-13-60, at 38 weeks of gestation because she had symptoms of pre-eclampsia. A Strogonoff regime was begun and the patient became overnarcotized, requiring intubation by the department of anesthesia. A consultation with a member of the obstetrical staff was requested 24 hours after admission. At this time the patient showed anasarca. Respirations were labored and irregular and of the Cheyene-Stokes variety. Heavy sedation of the Strogonoff technique was evident in slow responsiveness and slurring of speech.

The blood pressure was 110/70 at this time, but varied up to 176/120. Temperature was 102° F. A purulent discharge was present in the nasopharynx, but the chest was clear. The heart was normal to auscultation. The abdominal examination revealed a term pregnancy in the vertex presentation; FHT 140/ min. Marked edema of the face, abdominal wall and extremities was evident. Rectal examination revealed the head at a minus one to minus two with a closed, thick, but stretchy cervix. The urine contained four-plus albumin. She had been previously transfused with 1,000 cc of whole blood because of anemia.

The past history was notable in that seven years previously she had delivered a six-pound-11 ounce infant, and that four years previously she had delivered a six-pound infant by induction because of toxemia. In 1959, 29 grams of thyroid tissue were removed in the course of a thyroidectomy. The pathological diagnosis was Hashimoto's disease.

A medical course of management was begun with the hope that the condition would improve sufficiently for induction. Tetracycline was begun for the upper respiratory infection. On 10-14-60, the 24-hour urinary output was 1100 cc. However, this diminished thereafter. Output per hour varied from one to six cc. The blood pressure remained below 140/110. Because of the diminishing urinary output, induction of labor was begun with artificial rupture of the bag of waters and cytacinon. A continuous caudal anesthetic was also administered. The first stage of labor, which lasted nine hours and 45 minutes, terminated in the spontaneous delivery of a male infant on 10-16-60, at 6:00 A.M. Pertinent laboratory data are summarized in Table 1.

The infant was depressed, and resuscitation was necessary. The amniotic fluid was greenish in color; the urine output on the first post-partum day was 1263 cc, and on the second day it was 3155 cc. By the fourth day diuresis was brisk, with 5725 cc urinary output. Blood pressure remained at normal levels and the edema noticeably diminished.

Oral intake remained poor in the post partum period, and the patient was nauseated and vomited. On 10-25-60 an icteric tint to the sclerae was noted. The liver was palpable 4 cm. below the right costal margin and was tender. Laboratory data at this time revealed the hematocrit to be 27 vol. per cent; hemoglobin 8.6 grams, and white blood count 6,850, with a normal differential. The initial and subsequent liver function tests are listed in Table II.

On a program of high protein and carbohydrate intake, with bed rest and supplementary vitamins, improvement was rapid. Within 3 weeks of the onset of jaundice icterus visibly receded and the serum bilirubin fell to normal levels.

By 12-2-60 the liver was no longer palpable and was non-tender. Marked pallor of the skin was evident, and the skin had a dry appearance. The patient complained of lethargy and coldness. There was a loss of the outer one third of the eyebrows.

Laboratory data at this time showed a hematocrit of 29 vol per cent; hemoglobin 9.25 grams; serum bilirubin 0.50 mg. per cent total. The clinical suspicion of myxedema was confirmed by a serum protein bound iodine level of 0.8 mcg. per cent (modified Barker method). Normal by this method is from 4 to 8 mcg. per cent.

Dessicated thyroid was begun with clinical improvement beginning on a dose of three grains daily.

In February, 1961, there was a gradual decrease in appetite, with an alarming weight loss of 35 pounds. Some intermittent diarrhea and nausea occurred. She

TABLE 1

SUMMARY OF LABORATORY STUDIES

	NPN	BUN	UA	SP. GRV.	Hb.	NA+	CL—	K+	CO_2	Proteins
10/13/60	36	15	4+ Alb.	1.022	7.6 gr.					
10/14/60	40.5	20	1+	1.008	9.6 gr.					
10/15/60	60	22.9				150	602	4.6		5.7/1.8
10/16/60			3+			133	600	4.0		
10/17/60			1+	1.005	7.6 gr.	138	535	7.8	41	
10/18/60		33.2	Trace			139	588	3.8		
10/20/60			Trace							
10/21/60			Trace							
10/22/60			2+							
10/24/60			Trace		8.4 gr.					
10/25/60			1+							

TABLE 2

LIVER PROFILE

	Urine Bile	Urinary Urobilinogen	Alk. phos.	Thymol Turbidity	Proteins Alb. Globulin	Bilirubin 1 min.	30 min.	Ceph. 24 hr. Floc.	48 hr.	Prothrombin Control	Patient
10/26/60	Trace	+1:160	18.3	0.9	5.85-2.85	1.32	2.05	Neg.	Neg.	20	18
10/31/60	Neg.	1:20	21			0.6	1.55				
11/ 2/60	Neg.	1:40						Neg.	Trace		
11/ 7/60			25			0.25	0.95				
11/10/60	Neg.	1:10				0.22	0.15				
11/11/60			20.7								
12/ 2/60						0.25	0.50				
3/17/61			6.8		4.34-2.26	0.12	0.65	Neg.	1+		

had remained amenhorreic and failed to lactate since delivery. All of these symptoms were aggravated by an upper respiratory infection, which necessitated re-hospitalization at St. Joseph Hospital in March, 1961. At this time the patient appeared emaciated and dehydrated. Her blood pressure was 80/62 mmg of Hg. There were clinical and X ray signs of broncho-pneumonia. Pertinent laboratory data showed anemia with white cells numbering 6,050, of which 50 per cent were segmented forms and 50 per cent were lymphocytes. The bromsulfalein test showed 12 per cent retention at five minutes. The patient remained afebrile, in a borderline state of shock and desperately ill, despite a relatively slight pneumonic involvement Treatment consisted of intravenous glucose, blood transfusions, chloramphenical, and oxygen.

Because of the poor response to these measures, it was conjectured that adrenal insufficiency was now a part of the clinical picture. Only minimal laboratory procedures were feasible, but these showed a serum sodium of 136 mcg/L, potassium 5.1 mcg/L, and chloride 620 mcg per cent. The Thorn test showed less than 50 per cent decrease in circulating eosinophiles after injection of 25 mg of ACTH. A 24 hour specimen of urine assayed 2.5 mgs of 17-Keto-Steroids (Drekter method, with normal 5-15 mg/24 hours.) X ray of the skull showed a normal sella turcica. Improvement occurred with administration daily of 50 mg of cortisone with 0.1 mg daily of fludro-cortisone. Blood pressure returned to normal limits, appetite improved, and a 24-lb weight gain ensured. The anemia improved and the pneumonic processes cleared She was discharged on substitution therapy consisting of cortisone, fludro-cortisone, thyroid extract, and estrogen supplement.

Discussion

This unfortunate woman demonstrated such a gamut of complications, related and unrelated to her pregnancy, that it was felt to be worthy of presentation.

The toxemia was not unusual, and the response to delivery was quite as expected. However, the appearance of jaundice on the 10th post partum day was an unanticipated event. In reviewing her course prior to this discovery, it was noted that an upper respiratory infection

had been present on admission to the hospital. Anorexia was prominent as was nausea with occasional vomiting. These symptoms, while not always part of toxemia, were easily ascribable thereto. The true significance became evident only with the appearance of jaundice; the diagnosis of viral hepatitis was most compatible with the clinical picture at that time. Admittedly, there was reason to question the differential diagnosis of jaundice in the post partum state. The role of the hepatoxic drugs, including the phenothiazine group were investigated and ruled out. Alcohol was not a part of the picture, and no prior episodes of jaundice suggested a post necrotic cirrhosis. There was no support for hemolytic jaundice in laboratory or clinical data. Calculus disease of the biliary tract was considered, but ruled out because of the painless course, absence of prior symptoms of cholecystitis and liver enlargement and tenderness. Admittedly the flocculation tests were negative on two testings, but this is not unusual in hepatitis, and occurs in 15 to 20 per cent of the cases.[2] Serum transaminase determinations were not made but might have been helpful.

The clinical course and recovery were entirely compatible with that of a viral hepatitis. The possibility of serum hepatitis may be ruled out by the absence of contact with blood and blood products for a sufficiently long period prior to onset of the illness. The clinical course also ruled out the possibility of neoplasm of the pancreas or of the biliary tract.

The other possible cause of jaundice to be considered is that of the idiopathic jaundice of pregnancy. Sufficient discussion of this has been noted by Swedish and other authors to warrant designation as a clinical entity.[3-8] This condition is characterized by jaundice appearing usually during the third trimester. Onset is frequently with a generalized pruritus followed later by jaundice. The course is benign with absence of constitutional symptoms and discomfort to the patient. Difference in the literature has been denoted in regard to the presence of hepatomegaly. Svanborg states it was not noted in his 22 cases, but Kirsner reported liver enlargement in his case report.

Liver function tests and liver biopsy in recurrent jaundice of pregnancy are compatible with a defect in bile flow with biliary stasis. Whether intra hepatic or extra hepatie is conjectured on the basis of biopsy reports by Svanborg who reported normal bile duct visualization in his 22 cases. He did note 4 of his cases had gall stones, which were considered incidental.

All reported cases recovered in two to four weeks after delivery. Prognosis is good for both mother and fetus since no residual hepatic damage has been reported in either.

The eponym "recurrent" has been attached because of the peculiar propensity for this condition to recur in subsequent pregnancies. The pattern is so constant in some cases that the time of onset during the pregnancy has been predictable on the basis of occurrence of jaundice in previous pregnancies.

It is felt by Thorling that many cases of pruritus gravidorum may be due to milder forms of this condition without jaundice since pruritus is such a common accompaniment of this condition. He has found elevation of alkaline phosphatase in these patients beyond the usual physiologic elevations of pregnancy.

The course of this patient's jaundice was felt to be due to viral hepatitis because of the onset following symptoms of an upper respiratory infection with fever, anorexia, nausea, and vomiting. Admittedly, this portion of the picture was clouded by her toxemia. Later, however, the tended enlargement of the liver was more compatible with hepatitis than recurrent jaundice of pregnancy.

This case illustrates the need for adequate and vigorous care of toxemia and interruption of pregnancy at a date consistent with adequate control and viability of the fetus.

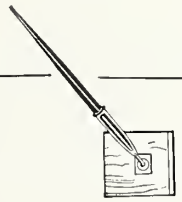
During the late post partum period, the triad of myxedema, hypogonadism, and adrenal insufficiency became clinically evident. This is compatible with a diagnosis of Sheehan's syndrome—post partum panhypopituitarism. Her response to substitution therapy was quite satisfactory.

The myxedematous state in this patient could be ascribed to the past diagnosis of Hashimoto's disease and thyroidectomy. It was only under the stress of a respiratory infection that the clinical state of adrenal insufficiency became evident and suspect. These multiple endocrine deficiencies then introduced the possibility of a diagnosis of Sheehan's syndrome.

It must be admitted that this is a presumptive diagnosis, but it is interesting also to note that some of the cases described by Sheehan followed severe toxemia. The authors believe this is a little known fact which should be important in the management of toxemic patients in whom milder degrees of adrenal insufficiency become clinically evident only under stress conditions.

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Address manuscripts to T. R. Van Dellen, M.D., Editor, Illinois Medical Journal, 360 N. Michigan Ave., Chicago 1, Illinois.

H. Close Hesseltine, M.D., Past President of the Illinois State Medical Society, has made some significant statements regarding the AMA's stand on cigarette smoking. We call your attention to the fact that these remarks appear on page 497.

Rheumatic Fever Prophylaxis In Downstate Illinois

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In 1956, the Illinois Department of Public Health, with the cooperation of the Illinois Heart Association, the Chicago Heart Association, the Illinois and Chicago Medical Societies and the Illinois Division of Services for Crippled Children initiated a program for the secondary prevention of rheumatic fever and rheumatic heart disease.*** This program provided for:

A. Free distribution of prophylactic medication to medically indigent residents of Illinois regardless of age who have or have had rheumatic fever or rheumatic heart disease.

B. Local registries which are coordinated by the State Health Department Central Registry.

C. A program of education to increase awareness of the importance of continuous prophylaxis against beta hemolytic strep infections in persons having a history of rheumatic fever or rheumatic heart disease.

Responsibility for administrating the program was delegated to the Division of Hospitals and Chronic Illness.

During the first year and a half of program operations, the necessary drugs were purchased with money from general health funds. In 1957 the 70th General Assembly passed Senate Bill No. 440 which provided $150,000 specifically for a program of secondary prevention of rheumatic fever or bacterial endocarditis. This amount was subsequently added to the budget for the Department of Public Health and is used for the purchase of the necessary drug supplies.

Sulfadiazine tablets (0.5 gms.), penicillin tablets (250,000 U.) and benzathine penicillin (1,200,000 U.) for injection are the drugs supplied. The tablets are supplied in amounts sufficient for a dose of one or else two tablets daily and the benzathine penicillin is supplied for monthly injections. A three months supply of either of the tablets or the injectible is distributed. The tablets are given or sent to the patient and the injectible penicillin is dispensed directly to the physician. A temporary increase in the amount dispensed occurs occasionally if unusual need is indicated.

In 1956 the State Health Department encouraged local health departments having an active heart association chapter to proceed with the approval of the County Medical Society in establishing a rheumatic fever registry and a program of secondary prevention of rheumatic fever.

It was intended that all known cases of rheumatic fever and rheumatic heart disease in the downstate area be registered. Only those who were medically indigent would receive free medicine from the State. The registration of those who were not medically indigent went so poorly that this phase of the program was soon discontinued. The rheumatic fever program has become an integral part of the services provided by the local health departments. Those areas of the state which are not served by one of the twenty-nine local health departments receive limited services from one of the state's five regional health offices. Since 1958 all of the state's 102 counties have had residents on the registry.

Physicians who wish to register patients on

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***Like some other State Health Department programs, the City of Chicago administers its program separately. For this report, the Chicago register information has not been combined with the State register and therefore this report covers only the downstate experience.

the program secure initial registration forms (RF-1) from the local health department, regional health office or in some locations from the local chapter of the heart association. This form (RF-1) contains items of patient and physician identification, disease manifestations, and a prescription blank for a three months supply of prophylactic medicine. One copy of the completed form is retained by the physician, while the other two copies are forwarded to the local health department or regional office. Jurisdiction is generally based on the home address of the person being registered. The forms are reviewed. Sometimes it is necessary to ask the attending physician for additional information. After the review is successfully completed, the prophylactic drug is dispensed and the original of the form is forwarded to the central registry at the Illinois Department of Public Health. Here the forms are again reviewed, coded, and sent to the State Health Department, Bureau of Statistics, for tabulation.

The follow-up form (RF-2) contains items of physician and patient identification, recurrences, cardiac status, regularity of prophylaxis and possible interruption of prophylaxis. There are also items to be completed if the registrant is being removed from the program. The right-hand side of the form (RF-2) is a prescription blank for a supply of medicine.

Follow-ups were irregular during the first year of the program with the period of follow-up varying from one week to one year. It quickly became apparent that this system was too cumbersome to handle large numbers. An analysis of the forms for the first year revealed that a three months follow-up period was designated most frequently. Since 1958 this has been the routine follow-up period. On the 20th of each month the follow-up forms due for the next month have the items of physician and patient identification printed in and are sent by the central registry to the local or regional health officer. He forwards them to the attending physician or to the patient depending on locally preferred procedure. After completion by a physician the forms are returned to the local or regional health office. This office reviews the forms, dispenses the appropriate supply of drugs and forwards the form to the central registry. The drug supplies of the local or regional health office are replaced monthly according to drugs distributed during the previous month. Since most health departments have a fairly constant rate of distribution, this replacement method works very well.

Both the initial registration (RF-1) and follow-up form (RF-2) must be signed by a physician.

The central registry is in the State Department of Public Health, Division of Hospitals and Chronic Illness. The original of the initial registration form (RF-1), each follow-up form (RF-2), a summary card for each registrant, and pertinent correspondence are kept on file. This registry assists the local health departments in matters involving policy.

The local and regional health offices keep records similar to those in the central registry. These offices also have the responsibility of dealing directly with the physicians and registrants. At the present time 27 counties and nine communities or townships are served by full-time health departments. This places the bulk of the geographical area and almost half the registrants under the auspices of the five State regional health offices. This broad responsibility does not allow the depth of coverage possible on the local health department level. In most instances the regional offices are not able to provide follow-up on a personal basis.

Delinquency is one of the major problems of this registry. It requires a great deal of work of a personal nature to follow-up delinquent cases. A registrant having a follow-up pending for six or more months is considered delinquent. The list of delinquents prepared by the Bureau of Statistics is distributed through the central registry to the local and regional health offices. If a registrant resides within the jurisdiction of a local health department, attempts are made to contact him personally as well as by mail. If this is to no avail, his physician will be contacted. If this does not produce clarification of the patient's status and the patient still can not be located, the case will be closed as "lost to follow-up."

If heart disease is present, extra effort is expected to locate and if possible persuade the registrant to return to routine prophylaxis. The presence of cardiac involvement usually makes persuasion easier. The personal contact that is

possible on the local health department level is valuable here and also in routine administration of the program. It allows education of the patient as to the need for prophylaxis and provides opportunity to give encouragement to those who are faltering. Should delinquency occur follow-up is much easier if rapport has been previously established.

Due to bookkeeping procedures no cases were closed during the first three years of the program. By 1959 the pending files had hundreds of cases that were far overdue for a refill. Methods of case closure were re-emphasized and the follow-up procedures presently in use were instigated.

Findings of the Registry

Since 1956 when the program was initiated in downstate Illinois, approximately 7,000 persons have received nearly six and one-half million penicillin tablets, half a million sulfadiazine tablets and 12,000 ampules of injectible benzathine penicillin.

Of the three thousand physicians in downstate Illinois who might be expected to treat rheumatic fever, 1,344 have registered patients to date.

Registration totaled 6,855 as of December 31, 1961 (Table 1). There were 5,202 currently receiving prophylactic medicine from the State. Approximately 40 per cent of those registered during the first two years of the program are no longer active. (Table 1) Those registered in the next three years dropped out at a rate of almost 10 per cent for each year on the registry and 3 to 4 per cent during the actual year of registration. This last mentioned rate is demonstrated by the figures for the 1961 registrants. The total drop out for patients registered during the first two years was substantially less than what might be expected on the basis of the drop out rate for subsequent years. The most likely reason that could be found was that 48 per cent of the cases registered during those first two years had heart disease.

Since 1959 a total of 1,653 cases have been closed (Table 1). It has been exceedingly difficult to come up with much information about the reasons for closing these cases. This is illustrated by the analysis of the figures for 1960 and 1961 (Table 2). Approximately three-fourths of the cases are listed as being "closed by physician," "closed by patient" or having been "lost to follow-up." These are very non-specific terms. Attempts to get more specific information have been extremely time consuming and unrewarding.

One-fourth of the closed cases have clearer reasons indicated such as "moving out of state, death and incorrect diagnosis." This last mentioned reason accounts for two per cent. There is a recognized need for an evaluating of a representative number of the cases that are closed so that the reasons for case closure can be accurately evaluated.

In this program emphasis is placed on the

TABLE 1
Closed Cases, Number Registered, Remaining Closed and Per Cent Closed by Year of Registration Downstate Illinois Registry as of Deeember 31, 1961

Year of Registration	Number Originally Registered	Number Remaining	Number of Cases Closed	% Cases Closed
1961	1325	1289	36	3
1960	1284	1108	176	13
1959	1339	1011	328	24
1958	973	632	341	35
1957	879	538	341	38
1956	1055	624	431	40
Total	6855	5202	1653	24

Source: Rheumatie Fever Registry
Illinois Department of Public Health

TABLE 2
Closed Cases, Number and Per Cent by Reason for Case Closure Downstate Illinois Registry—1960 & 1961

Reason for Case Closure	Number	Per eent
Closed by Physieian	397	38%
Closed by Patient	189	18%
Lost to Observation	205	20%
Moved out of State	184	18%
Died	39	4%
Not R.F.	18	2%
Total	1032	100%

Source: Rheumatie Fever Registry
Illinois Department of Public Health

TABLE 3
Age at Time of Registration and Per cent of Total Registry by 5 Year Age Groups
Downstate Illinois Registry—December 31, 1961

Age	Number	Per cent
Total: All Ages	5202	100%
Total Under 20	4119	79%
Under 5	220	4%
5- 9	1649	32%
10-14	1671	32%
15-19	579	11%
Total 20 and over	1083	21%

Source: Rheumatic Fever Registry
Illinois Department of Public Health

TABLE 4
Major Manifestations of New Cases by Number and Percent
Downstate Illinois Registry, 1961

Manifestations	Number	Percent
Polyarthritis only	504	38%
Carditis only	172	13%
Polyarthritis and Carditis	251	19%
All others singly or in combination	165	12%
No history of Manifestations	233	18%
Total	1325	100%

Source: Rheumatic Fever Registry
Illinois Department of Public Health

TABLE 5
Population, New Cases and Rate Per 10,000 by 5 Year Age Groups
Downstate Illinois, 1961

Age	Downstate Population	New Cases	Rate Per 10,000 Population
Total	6,592,709	1325	2.0
Total Under 20	4,356,749	982	2.2
Under 5	751,665	52	0.7
5- 9	691,244	383	5.5
10-14	598,877	389	6.5
15-19	470,268	158	3.3
Total Over 20	2,235,960	343	1.5

Source: Rheumatic Fever Registry
Illinois Department of Public Health

need for prophylaxis in the child and young adult. This is of course the time of greatest incidence of occurrence and danger of recurrence. Registration forms for older persons are evaluated more closely.

These factors together with the tendency of not placing adults on prophylaxis unless heart disease is present probably account for the fact that 79 per cent of our registrants are under 20 at the time that they were registered (Table 3).

Heart disease is present in 37 per cent of all registrants. The percentage of heart disease for five year age groups gradually increases. It is nearly twice as likely to be present in the registrant over twenty as compared to the registrant under twenty. The per cent having no heart disease decreases correspondingly. The under five age group is an exception due primarily to the fact that questionable heart disease which is present in approximately 15 per cent of all other age groups is present in 21 per cent of this age group.

In 1961 polyarthritis was the only manifestation present in 38 per cent of those registered and 13 per cent had carditis (Table 4). The combination polyarthritis and carditis was present in 19 per cent of those registered. The other manifestations and possible combinations of Jones five major criteria accounted for only 12 per cent. This leaves 18 per cent of the registrants having no manifestations. Registrations for patients having rheumatic heart disease are accepted in the absence of manifestations. The only other situation that may account for any significant number of registrants having no manifestations given is when this registration provides a continuation of prophylaxis which was begun under another program of prophylaxis.

Tabulation of minor manifestations have not been carried out. The reguistration form has been revised so as to allow for routine reporting and tabulation of minor as well as major manifestations. These minor manifestations will be at least partially tabulated during the coming year.

Registration is greatest in the five to nineteen age group (Table 5), six out of every 10,000 persons in this age group are registered each year. If all known cases were registered, this could be expected to be as high as one per one thousand.

When these figures were tabulated, 83 per cent of the registrants were on schedule with their prophylaxis and only five per cent of the

TABLE 6
Status of Prophylaxis, Number and Percent
Downstate Illinois as of December 31, 1961

Status of Prophylaxis	Number	Percent
On Schedule	4313	83%
Failed to take Drug Regularly	245	5%
Follow-up Pending	644	12%
Total	5202	100%

Source: Rheumatic Fever Registry
Illinois Department of Public Health

registrants were not following their course of prophylaxis, (Table 6). Of the remaining 12 per cent, it is estimated that approximately two-thirds (eight per cent) were registrants due for follow-up during the month the tabulation was carried out. The remaining 4 per cent represents persons who have become delinquent and are being followed up by the local or regional health office.

Other statistics not presented in these tables were tabulated. It was noted that equal numbers of males and females were registered and that non whites accounted for less than four per cent of the registrants. In 1960 and 1961 some 53 per cent of the registrants had their initial attack within two years of the date of their registration with 40 per cent being within one year.

Discussion

The Rheumatic Fever Registry for downstate Illinois covers a large geographical area which includes both urban and rural societies. It is primarily a service of the Illinois Department of Public Health. Valuable support especially in the field of professional education is supplied by the Illinois and Chicago Heart Association. Clinical facilities and services are not included in this program but are provided by the Division of Services for Crippled Children.

The forms that are used provide a means of professional education as well as securing information about patients. Diagnostic and drug dose criteria are based on the recommendations of the Committee of Prevention of Rheumatic Fever and Bacterial Endocarditis of the American Heart Association. The analysis of the information obtained gives some indication of the status of rheumatic fever in this area but primarily represents the status of reporting to this registry.

The number being registered each year became fairly stable after the third year of program operation. The rate of drop out became stable after the second year.

Cardiac status varies in different age groups. Questionable heart disease has its greatest prevalence in those under five. Rheumatic heart disease increases in prevalence with each succeeding age group.

Since minor criteria were not obtained it is not possible to tell exactly how many registrants would have fulfilled the modified Jones criteria. Between twenty and thiry per cent had two or more major criteria given at the time of registration. Rheumatic heart disease which is in itself ample evidence of the need for prophylaxis was present in 37 per cent of the registrants.

Despite the difficulties that are encountered in the operation of this program, there seems to be an encouraging adherence to prophylaxis with better than 80 per cent of all registrants being on schedule.

Erythrocytosis Caused by a Renal Cyst with Remission of Polycythemia Following its Removal

John C. Kulis, M.D.

It has been established that erythrocythemia is associated with various renal diseases. The most common kidney disease to be linked with erythrocythemia is hypernephroma. However, conditions such as polycystic kidneys,[2] hydronephrosis,[3] benign renal adenoma,[4] sarcoma, tuberculosis, and hemangioblastomatous cyst[5] have also been identified with erythrocythemia.

The following report describes a case of asymptomatic erythrocytosis which was due to a plain renal cyst. To our knowledge this is the first such case to appear in the literature.

Case Report

On 4-1-62 a 40-year-old white male who had recurrent epigastric pain with associated dyspepsia for about three months was admitted to the hospital because this pain became intensified.

Physical examination revealed a robust white male with dry, scaly skin suggestive of ichthyosis. There was no adenopathy or thyroid enlargement. The chest was clear to auscultation. His heart, which was normal in size, had a sinus rhythm. Blood pressure was 130/84. There was no costal vertebral angle tenderness. There was, however, tenderness in the epigastrium, but with no rigidity. There was no hepatosplenomegaly. The extremities revealed no clubbing or cyanosis. Our impression at this time was that the patient was suffering from chronic cholecystitis with acute exacerbation.

Laboratory tests showed a normal chest X ray and electrocardiogram. BUN was 16, uric acid was 4.4 mg. Hematological findings revealed: On 4-1-62, Hb 20 gm per 100 cc, Hct 60 per cent, WBC 9,000. On 4-2-62, Hb was 19.5 gm per 100 cc, Hct was 59 per cent. The bone marrow showed erythroid hyperplasia with a myloid-erythroid ratio of 2 to 1.

Surgery was performed on 4-2-62. A pathological gall bladder which had several concretions (measuring up to two cm in diameter), and which had an irregular outline, was removed.

Post-operative findings revealed the same elevated Hb that the patient had exhibited on admission. A systematic approach was therefore conducted to discover the cause of the erythrocythemia. Attention was ultimately directed to the kidneys.

Kidney studies were carried out on 4-3-62. X rays on I.V.P. examination showed both kidneys to be functional. The left kidney was normal in size and shape. The right kidney was larger than normal, its general outline was not well defined, and its collective system was enlarged.

Retrograde showed the left kidney and ureter to be normal. The right kidney showed marked enlargement, being displaced posteriorly by a huge intrarenal mass. The collective system of this kidney was definitely distorted. There was delay in drainage of the right kidney, but the right ureter was normal.

Surgery was performed on this kidney on 4-3-62. A large cystic mass incorporating the upper and middle poles of the right kidney was found. The cyst was drained of approximately 1500 cc of a clear fluid which was not compatible with urine. This cyst was surgically removed. There was no evidence of neoplasm.

Pathological examination of the cyst showed it to be grossly made up of two grey, fibrous, resistant, masses of tissue. One of these measured 11.5 by 12.5 cm, the other 11 by 3.5 cm. On its inner surface the cyst was trabeculated. Microscopic examination revealed that the cyst wall consisted of a dense fibrous tissue which contained numerous thick and thin-walled blood vessels.

The cyst was devoid of distinct cellular lining, even though scattered spindle-shaped cells consistent with fibroblasts were observed. In some areas, focal collections of chronic inflammatory cells were seen throughout.

Diagnosis was that of a simple cyst of the right kidney.

Post-operative Findings one month following surgery showed that the hemoglobin and hematocrit began to drop down to more normal levels. By 11-20-62, about eight months following surgery, it had dropped to 15.3 gms (see Table).

From the Swedish Covenant Hospital, Chicago, Illinois

Table 1
HEMATOLOGICAL FINDINGS

Date	RBCs (millions)	Hemoglobin (gm per 100 ml)	Hematocrit (per cent)	WBCs (thousands)	Other Data
4- 1		20	60	9	Normal differential sed. rate-1mm per hour
4- 2		19.5	59		
4- 3	5.6				Platelets 256,000 clot retraction —clot began at 1½ hours— retraction was good
4- 4		19.5	59		
4- 9		18.5	57		
4-18		18.5	55		
4-26		17.8	53		
5- 1		15.7	50		
8- 4		13.6	40		
10-13		15.2	45		
11-20		15.3	45		

Discussion

Erythrocythemia is characterized by an elevation in the peripheral red cell count and hemoglobin concentration, increased red cell mass, normal numbers of white blood cells and platelets, and no splenomegaly. Plasma volume is normal. Bone marrow shows erythroid hyperplasia.

Erythrocythemia may occur as a secondary condition to any one of a number of disorders which produce hypoxemia. Cardiac veno-arterial shunts, pulmonary discase, obesity, high altitude, and abnormal hemoglobin are examples of such conditions. However, disorders which do not produce hypoxemia may also be associated with erythrocythemia. Uterine fibroid,[6] cerebellar tumors,[5] hepatomas,[7] Cushing's disease,[8] and renal disease (the most common), are disorders which do not produce hypoxemia, yet are often found linked with erythrocythemia.

Each of the above named disorders was considered before we made a diagnosis in our patient. After each disease entity was clinically eliminated from our consideration, we focussed our attention on the kidneys. Here, a right renal lesion was discovered, specifically identified, and surgically corrected.

Erythropoetin

Several investigators have demonstrated the presence of a hormone—*erythropoetin*—in the plasma and urine of anoxic, anemic, and cobalt-treated animals. Apparently this hormone in some way stimulates erythrocyte production. The manner in which erythropoetin is produced by the body is still not well understood. Jacobson and his co-workers[9] suggest that erythropoetin is synthesized in the kidneys.

In recent years erythropoetin has been implicated as playing a primary role in producing polycythemia. Elevated plasma levels of erythropoetin have been demonstrated in patients with erythrocythemia of renal disease.[10,11] An erythropoetic active substance has been extracted from the cystic fluid of one polycystic kidney in a patient with erythrocythemia.[12] Our hospital, unfortunately, was not equipped to assay the cystic fluid from our patient.

Summary

A case of erythrocythemia was described. The return to normal blood levels eight months following surgery in which a plain renal cyst was removed strongly suggests that erythrocythemia was caused by the cyst.

We would like to stress that erythrocythemia is usually reversible when the primary disorder is corrected.

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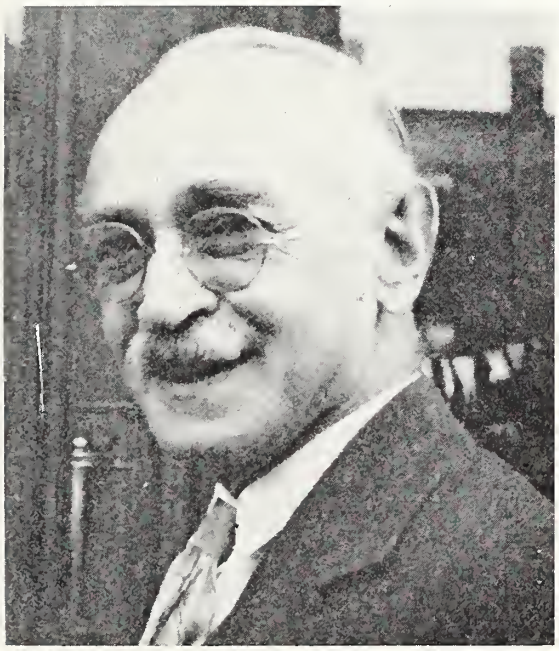
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The History of Neurology in Chicago

Roland P. Mackay, M.D., *Chicago*

This is the fifth installment of an informative history of neurology not only in Chicago as the title would indicate but throughout the state and the nation. In a delightful and interesting style, Dr. Mackay paints a picture of the growth of neurology as seen against the times in which it was practiced—a story of a city and specialty growing together.

Sidney Kuh, born in 1866 in New York, received his preliminary education in German *Gymnasia* and in 1885 entered the Chicago Medical School, only to go the next year to Heidelberg where he graduated in medicine in 1890. For two years he was assistant to Wilhelm Erb, and saw the work of Kraepelin. He began practice in Chicago in 1893 and was recognized as one of the few "properly trained" neurologists in Chicago. He was appointed neurologist at Michael Reese Hospital where he organized a "real" clinic in neurology. Further, he was well grounded in psychiatry and worked for years to raise the standards at the old Chicago Detention Hospital.



Sidney Kuh
(1866-1934)

Dr. Kuh was an original member and first Recording Secretary of the Chicago Neurological Society and its President in 1904. In 1906 he was elected to membership in the American Neurological Association. He was also a member of the Chicago Pathological Society, the Physician's Club of Chicago, the Chicago Academy of Medicine and the Society of Medical History of Chicago.

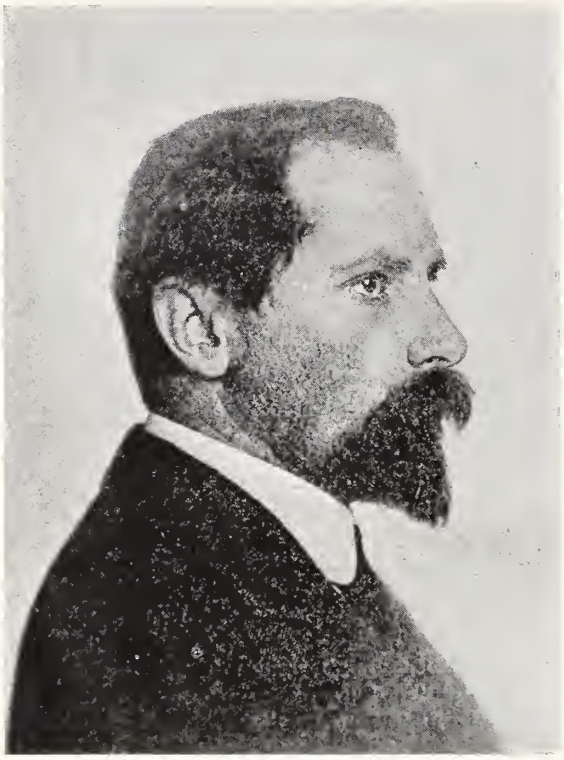
Although not a prolific writer, he published some 25-30 articles over a wide range of topics. He was reputed a good clinician, but his often caustic tongue and his love for pricking "neurological bubbles" lessened his popularity. He never married and was something of a mysogynist, thought Freud's psychoanalysis "dangerous," hated medical meetings and their frequent banalities, and cared little for power and position. He died on December 27, 1934.

Adolph Meyer deserves to be included in this history because of his eminent position in neurology and psychiatry in this country, although his connection with Chicago was almost nonexistent and with Illinois only brief. Born in Switzerland in 1866, educated in Europe, and licensed in 1890, he came to Illinois at the invitation of Clevenger in 1893, to assume the duties of pathologist at the Eastern Illinois Hospital of the Insane at Kankakee. While serving in that capacity he also taught at the University of Chicago. Although he worked in Illinois only 2 years, he introduced new methods of laboratory technic, did a great deal of sound

Read before the International College of Surgeons, Chicago, Illinois, March 19, 1963. Excerpts of this article appeared in the journal of the International College of Surgeons, August, 1963 under the same title.

Professor of Neurology, Northwestern University Medical School, and Senior Attending Neurologist, Chicago Wesley Memorial Hospital.

*For much of the material here presented on the general history of Chicago, I am deeply indebted to Emmett Dedmon's *Fabulous Chicago*.[1]

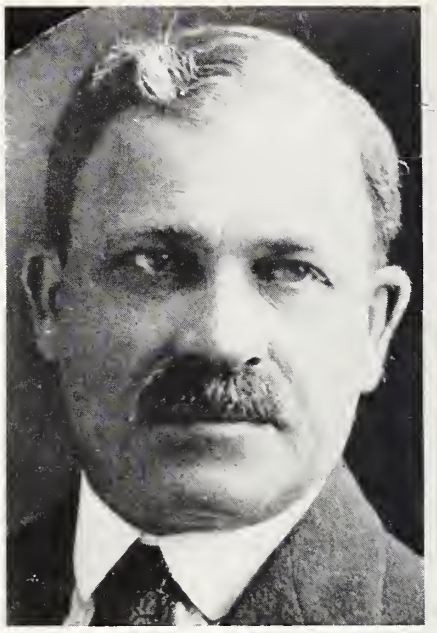


Adolph Meyer
(1866-1950)

work, and furnished the material for an important volume of pathological reports.[18] He left Kankakee in 1895, returning to Worcester, Massachusetts and later to Johns Hopkins University, where in 1912 he became head of the Psychiatric Clinic at its foundation.

Adolph Meyer, reversing the usual trend, began as a neurologist and only later used this solid foundation for a broad and creative attack upon the problems of the personality and its disturbances. He was therefore the forerunner of the present neurologic approach to psychiatry—an approach which may eventually rescue phychiatry from the mystics. After a long and fruitful life, he died March 17, 1950.

Julius Grinker, one of the most enigmatic but appealing personalities on the Chicago neurologic scene, was born in 1867 in Koenigsberg, Prussia, of poor Jewish parents. His father died when Julius was a child; his stepfather was also poor. When he was 15 Julius came with his family to New York, but they were admitted only after delay and with help from friends, because of poverty. At 17 he left home and became a typesetter supporting his stepfather and



Julius Grinker
(1867-1928)

the rest of the family, including two new children. He beat his way on freight trains westward in quest of gold, but when, in Iowa, his partner broke his leg, he returned to New York, typesetting, and night school. Eventually he began the study of medicine under the preceptorship of a Dr. Adler of New York, and graduated in medicine at the New York Medical School, in 1891, when 24 years of age. In the same year he came to Chicago and started general practice. This was a difficult time financially, something already well known to him, but he was eventually successful and married in 1899. In 1900 he heard a lecture at the Chicago Polyclinic by Dr. Hugh T. Patrick and, impressed, promptly adopted neurology as his professional specialty.

Realizing his need for special training, he went to Vienna and cut brains in Obersteiner's laboratory and worked in the neurological clinics. Back in Chicago, his restriction of his practice to neurology greatly reduced his income and his wife's family strongly opposed his specialization. But he resolutely refused to turn back or to accept financial aid from his father-in-law, but struggled on in magnificent independence, doing his private practice and working and teaching in the Northwestern University and Postgraduate Medical Schools, soon becoming a Professor in the latter and Asso-

ciate Professor in the former. He worked also at the Cook County Hospital and at the Oak Forest Infirmary. He was greatly interested in medical meetings, especially those of the Chicago Neurological Society, of which he was president in 1923-4.

He wrote on a wide variety of neurologic topics—tumors, syphilis, trauma, multiple sclerosis, almost everything. His first paper, published in the Illinois Medical Journal in 1903, was on acromegaly with epilepsy; the second, in the same volume, was on combined cord degeneration and pernicious anemia. There were 15 articles from 1903 to 1905, and 58 in 20 years. Of these, only eight were on psychiatric subjects, between 1904 and 1914. His paper "Freud's Psychotherapy," in 1912, was the first from Chicago on the subject. As his son Dr. Roy R. Grinker notes in recently published reminiscences,[19] there was "a psychoanalytical historical island in Chicago" between 1911 and 1914, in which a lively interest was shown in Freud's ideas, with sincere efforts on the part of Grinker and others to understand and test them, although acrimonious disputes rather than calm discussions, and early failures by the neurologists experimenting with psychoanalysis, put an end to efforts of this sort.

In 1926 Grinker retired in poor health, and died in 1928. He had been tenacious, determined and independent, perhaps harsh, but his iron will and unbending perseverance won his success and earned our admiration.

George Washington Hall was in many respects the perfect example of the combination of neurologist and psychiatrist in one practitioner. Born near New Market, Indiana on June 18, 1868, he graduated in medicine at Rush Medical College in 1893 and became, along with James C. Gill, assistant in private practice to Daniel R. Brower, who, at 54, was by now a prominent neuropsychiatrist and Professor of Neuropsychiatry. In the same office was E. Fletcher Ingals, an eye, ear, nose and throat specialist. Hall was first Instructor in Laryngology at Rush from 1895-1902, then in Medicine from 1902-6, and Assistant Professor of Medicine from 1906-11. In 1904 he did postgraduate work in neurology in London, and in 1907 returned to London, where he became a close friend of Kinnier Wilson, and went on to Vienna and Munich for



George Washington Hall
(1864-1941)

further study. He was Associate Professor of Nervous and Mental Diseases at Rush from 1911-25, and Clinical Professor from 1925 to his death in 1941. During his career he served both as neurologist and psychiatrist in various ranks at the Cook County and Presbyterian Hospitals until 1916, when he became Senior Attending Neurologist and Head of the Department at St. Luke's, positions which he held until his death. In 1934 he organized the first psychiatric unit in a private general hospital in Chicago, at the time when shock therapy by intravenous metrazol and insulin was first used. This unit was phenomenally successful and at once imitated in other private hospitals in the city. He was an original member of the American Board of Psychiatry and Neurology, which held its first examination in Philadelphia in 1935.

Hall's medical interest was in neurology, his emotional allegiance to psychiatry. Practically all his papers were on neurologic topics, but he had no time or inclination for the minutiae of neurology as a fine art, nor was he greatly skilled in it, although his superb clinical sense made him a most valuable consultant in critical cases. He was one of the first to use intravenous typhoid vaccines for the febrile treatment of general paresis, and with greater success than others achieved because he knew enough to

give increasing doses of sufficient size to obtain adequate fever. He pioneered in using such vaccines in the treatment of multiple sclerosis but of course without success. Psychiatry, on the other hand, was for him an exercise in the understanding and handling of people, for which he had a great flair. These subtleties he could not set down in scientific terms, or express in written papers, for as a psychiatrist he was not so much scientific as intuitive. In every discussion of the problem of diagnosis he urged, as the physician's chief duty, the appraisal of emotional as well as physical factors in the genesis of symptoms,—an elementary necessity often (and I fear increasingly) forgotten in modern medicine. In truth, his shrewd and direct insight into human personality and predicament was his greatest skill, making him indeed a premier clinician. Physically, he was short, stocky and jovial, full of earthy wisdom and an extrovert of the purest breed. He died in the night in his hotel room at the meeting of the Central Neuropsychiatric Association in Detroit, October 25, 1941.

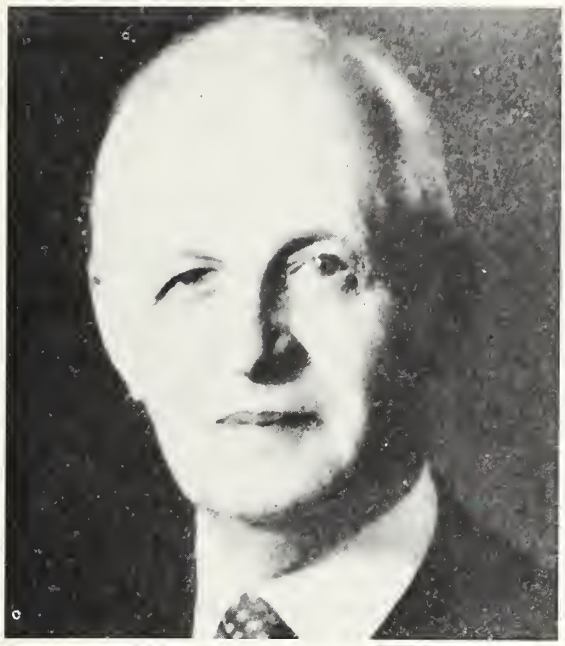
The Chicago Setting, 1900-1925

In the first quarter of the twentieth century, Chicago's phenomenal growth continued. The population rose from two million to three, at first largely by immigration from Europe, but after the first World War by an influx from the southern states. It is said that within two years the negro population of Chicago quadrupled.[1] The restless energy of the city, the febrile search for wealth, the daring experimentation with the new, seemed limitless. Genius flowered here in many fields, but often departed with its laurels. By 1910 one fifth of the world's movies were made in Chicago,[1] until its brutal winters and lowering skies drove that industry to the warmth and light of California. A literary renaissance sparkled with rebellion against the staid, the stupid and the corrupt. Frank Norris, Theodore Dreiser, Upton Sinclair were among its lights; Harriet Monroe's magazine *Poetry* and Margaret Anderson's *The Little Review* opened new paths in verse and criticism not only for Chicagoans like Carl Sandburg, Edgar Lee Masters and Vachel Lindsay, but for others from far and near, like T. S. Eliot, Robert Frost, John Masefield, Vincent Starret and Sherwood Anderson, while the respectable and conservative *Dial* fulminated against the innovators. Eventually many rebels moved on to New York or Paris. Jazz musicians from New Orleans came to hammer out true Chicago jazz and Benny Goodman got his start, only to find a more appreciative audience in the east.

In this first quarter of the twentieth century the fatuous mayor William Hale Thompson brought the alliance of politics and crime to a new record of infamy, as politicians high and low thrived on the profits of violence, and gang wars raged under the diabolical leadership of Jim Colosimo, John Torrio, Dion O'Banion, Tony Weiss and the incomparable Al Capone whose chief skill was murder. But in this period flourished the Chicago Opera Company under the baton of Cleofonte Campanini, Mary Garden presented her scandalously voluptuous *Salome* and an unknown named Galli-Curci shook the world at her debut in 1916. It was also in this period that the last tycoon of them all, Samuel Insul, built his electrical empire and his delusions of grandeur, before the great depression of the 1930's drove him out of the country, a fugitive from justice.

Apparently the medical profession in this era remained guiltless alike of crime and the arts. If, as has been hinted, some of the surgeons were, in their own way, tycoons, that is not our concern. But neurology, at least, preserved its severe devotion to scientific labor and humanitarian ends. During this period death ended the careers of the great Lyman at 69, Brower at 70, the gentle, studious Bannister at 76, the versatile, volatile Clevenger at 77, Oscar King at 70 and Harold Moyer at 65. But others came forward to take their places.

Peter Bassoe, the clinician's neurologist, was born at Drammen, Norway, on May 18, 1874, the son and grandson of Lutheran ministers. He came to the United States at the age of 19 and taught in a country school at Decorah, Iowa. Upon graduation in medicine from Illinois in 1897, he promptly wrote first place in the Cook County Hospital's interne examination. In 1898 he became assistant physician at the Mount Pleasant State Hospital, in Iowa, but two years later went to the Massachusetts State Hospital at Worcester to work with Adolph



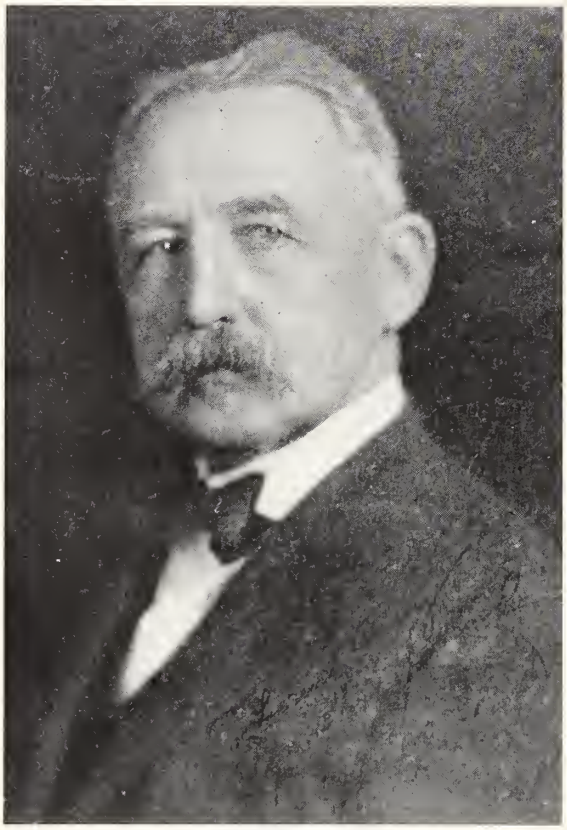
Peter Bassoe
(1874-1945)

Meyer, recently arrived from Kankakee, Illinois. Only a year later, in 1901, he began study in Europe at Heidelberg, Montpellier and Prague, but returned to Chicago when taken seriously ill with acute nephritis. From 1902 on, he worked as pathologist at Presbyterian Hospital, where he was acquainted with Thor C. Rothstein who was working at the time in neuropathology at Rush Medical College. Bassoe returned to Europe in 1906 for more postgraduate study in Berlin, Paris and London.

Upon his return in 1907 he may be said to have begun his real Chicago career in neurology. He became personal assistant to Dr. Hugh T. Patrick, and was appointed Attending Neurologist at the Cook County Hospital and Assistant Professor of Nervous Diseases at Rush Medical College. From 1910-18 he was associated with Dr. Patrick as Editor of the Year Book of Nervous and Mental Diseases, and then the sole editor of that volume until 1933. During these years of editorship his familiarity with neurologic literature became extensive, and his name known over the world for his discriminating choice of material for the book. In 1911 he was elected a member of the American Neurological Association, but noting that that eminent national body was dominated by neurologists of the eastern seaboard, he began to plan the Central Neuropsychiatric Association, which he founded in 1922 and served as first president. It was his plan that this group of neurologists from the Alleghenies to the Rockies should rotate its annual meetings among the several cities of the members, and so see at first hand the home-grown neurology of the midwest. He also thought that the wives of members should not be brought to such meetings, lest they dilute scientific with social interests. The Central Neuropsychiatric Association still meets in the midwest cities to hear scientific papers by the hosts, but it has grown much larger, and indeed more social, largely through the presence of the ladies.

Bassoe had broad neurologic interests, wrote over 100 papers on a wide variety of topics, from caisson disease to "tick paralysis," from acromegaly to medical history. He was a member of many societies, and sooner or later president of most of them. Primarily a neurologist, he found psychitary woven into the fabric of neurology, and indeed of all medicine itself. With an even widening practice and the demands of his editorial work he had little time left for pathology or research, and often collaborated in scientific contributions with the neuropathologists, George Hassin and Roy Grinker. As Bailey has remarked, he was a serious person, with no time for games or frivolity or the ribald anecdotes of medical jokesters. He was so modest as to be self-effacing, unfailingly gentle and courteous, his voice a soft Norwegian echo. His erudition was as genuine as the shyness that hid it, his tolerance a constant protection from strife. He died of coronary thrombosis November 5, 1945, aged 71.

Thor Christian Rothstein was born in Kristianstad, in southern Sweden on October 20, 1864. He graduated at the University of Stockholm in 1897 and did postgraduate work on the histology of the renal epithelium with the great Swedish anatomist, Retzius and later in Paris with André-Thomas. In 1898 he came to the United States and, like many another Swede, took up his residence in Minnesota, entering general practice, including especially thyroid surgery, in Minneapolis. For reasons unknown, he moved to Chicago to continue general practice, living on Green Street, but was influenced toward neurology by Ludvig Hektoen. In 1903



Thor Christian Rothstein
(1865-1937)

he was appointed Research Assistant in Neuropathology at Rush Medical School through the influence of Dr. Richard S. Dewey, who gave him the brain of a manic depressive patient, which he examined and described pathologically in a paper by Dewey. At Rush he climbed the academic ladder from Assistant in Mental and Nervous Diseases, 1905-6, to Chairman of the Department, 1911-24 and Clinical Professor of Neurology 1924-31, after which he was Professor Emeritus until his death in 1937. He was Attending Neurologist at the Presbyterian Hospital from 1908-31 and Consulting Neurologist 1931-7, as well as Consulting Neurologist at the Augustana Hospital. He wrote, with Dr. Edward H. Ochsner, a paper on a case of multiple exostoses in the spinal canal in 1907, and reported in 1918 the vasomotor and sensory changes in the hands of eight stone cutters using the air hammer. But he never lost his interest in histopathology, collected a great number of microscopic slides on encephalitis after the pandemic of 1917-18, and published a paper with his young associates, L. W. Avery and Richard B. Richter on the histology of the normal dura mater and pia-arachnoid.

He was one of the most picturesque figures in Chicago neurology—a silent, sensitive, dour Norseman with great mustachios, large head, and forbidding mien. Some of his gruffness was a cover for his sensitivity. Despite his stern reserve, his patients found him a tireless and sympathetic listener, a physician whose austerity only increased the value of his warmth. He developed antipathies against certain other neurologists and absented himself from the Chicago Neurological Society to avoid meeting them. He pursued his lonely activities in the laboratory, having clinical office hours only three times a week and repairing to his microscope on Saturdays and Sundays at any and every hour. Despite this persistent work, he never accomplished much and published little, out of a fear to be wrong. But he was not without some vanity and affectation. In June 1930, King Gustavus of Sweden conferred upon him the Order of the North Star, with the rank of Knight. From the trip to receive the decoration he returned with a walking stick and monocle, which served to enhance his reputation for the picturesque—perhaps his calculated purpose. Death came to this complex man on February 19, 1937, when he was 73.

the intensity of your patient's tension...

Rx ATARAX®

(hydroxyzine HCl) tablets syrup parenteral

for any age–for any stage of anxiety

Powerful enough to ensure easy acceptance of surgery and anesthesia
Calm, cooperative quiescence is the state induced in apprehensive surgical patients premedicated with hydroxyzine HCl. Among its other advantages are the added antiemetic property which minimizes postoperative vomiting, and its mild potentiating action which frequently reduces requirements for adjunctive narcotics.

Safety record permits use in children and debilitated geriatric patients
Even after extensive use in patients ranging from very young to very old, Atarax (hydroxyzine HCl) has maintained an outstanding record of safety.

No matter how anxiety manifests itself, or how severe it is, you can count on hydroxyzine HCl for rapid, effective relief. The wide variety of dosage forms makes administration flexible by any standards of convenience, patient preference, or emergency requirements within the recommended dosage. You can adjust the dosage to whatever level best controls your patient's degree of anxiety. Oral dosage for adults ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Recommended dosage: 100 mg. to 150 mg. daily in divided doses. The daily oral dosage for children 6 years and under is 50 mg. in divided doses; for those over 6 years, 50-100 mg. in divided doses.

FOR EVERY DEGREE OF ANXIETY—IN PATIENTS UNDER 6 TO OVER 60

Side effects and precautions: Theropeutic doses of Atorox (hydroxyzine HCl) seldom impoir mentol olertness. If drowsiness occurs, it is usuolly tronsitory ond moy disoppeor ofter o few doys of therapy or with reduced dosoge. Mouth dryness moy occur ot high doses. In some hospitolized potients on high doses, involuntory motor octivity, not unlike thot seen with high doses of other psychotropic drugs, hos been reported olthough continued therapy with 1 Gm. doily hos been used in some coses without producing this effect. When some potients receive onticoogulonts ond hydroxyzine HCl concurrently, the onticoogulont requirement moy be decreosed; potients receiving both should be followed closely ond oppropriote loborotory studies performed regulorly. When hydroxyzine HCl is used with CNS depressonts, its mild potentioting oction should be token into considerotion. Soft tissue reoction, os seen with other injectobles, hos rorely been reported with porenterol hydroxyzine HCl.

In any condition where tissue depletion of the water-soluble vitamins is suspected, Rx **RoeriBeC*** therapeutic B-complex with 500 mg. of vitamin C. *TRADEMARK

Roerig

New York, N.Y. 10017
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being®

IMJ EDITORIALS

Indictment For Fraudulent Advertising

An advertising agency was indicted recently by a federal grand jury on charges of preparing fraudulent ad copy for *Regimen* tablets. The agency, Kastor, Hilton, Chelsey, Clifford & Atherton, Inc., prepared ads saying that the product would cause substantial weight loss without dieting. The FDA began to remove Regimen tablets from the market in January following the admission by the company that they were misbranded. The key ingredient is phenylpropanolamine hydrochloride, but the dosage was not enough to suppress the appetite.

This is the first time an advertising agency has been indicted as sharing the responsibility for preparing fraudulent claims for a client.

The results of this trial may influence advertising copy in the future. Advertisers may want more reliable proof of the value of a patent medicine before they join hands with clients who thrive on human gullibility. Most patent medicines contain reliable drugs. But the dosage is cut down to subtherapeutic levels. Fraud enters the picture when proof of efficacy is based on research conducted with the drug at therapeutic dosage levels.

We cannot feel sorry for the manufacturers of Regimen. During the six years in which the product was available more than four million boxes were sold for a total of about 10 million dollars.

Choose A Drug, Know It Well

It is virtually impossible for a physician to keep track of the constantly changing field of antibiotics and drugs. There are dozens of cough remedies, corticosteroids and antispasmodics. There are several antidiabetic tablets and many more diuretics. A doctor must decide which one of each group will be most beneficial for his patient. Dr. Maxwell Finland, of Boston, offers his advice to physicians whose time does not permit reading all the material that crosses his desk. Choose one drug in a given category and know it well.

When a new class of drugs is presented, find out all you can about it, determine if similarities exist between it and a drug that is in use, categorize it, and use it. This seems like a very workable idea.

This idea is not new. Prior to World War II, the physician wrote lengthy prescriptions but the majority utilized less than 30 drugs in their day-to-day practice of medicine.

The physician learns about new drugs from many sources. All drug manufacturers provide extensive information on their products. This is done by package inserts, labeling, brochures, and detail men.

Another source is the section in the JAMA that evaluates new drugs. These articles are not to be construed as approval, endorsement, or acceptance of the drug. They merely present an assessment of the drug based on current available evidence. When unfavorable reports come in, they are also presented.

T. R. Van Dellen, M.D.

The One Tranquilizer that Belongs in Every Practice

Miltown®
(meprobamate)

... *practical for control of anxiety and tension*

- Relieves anxiety and tension without significant effect on alertness and reflexes—especially valuable in the working patient.
- Established and accepted—more than ten years' use, more than 1500 published papers confirm its value.
- Broad therapeutic range—may be used whenever anxiety and tension are present, with or without organic disease, in any age group from pediatric to geriatric.
- Relaxes both *physical* and *emotional* tension, thus helping to establish normal sleep patterns.
- Proven safety/efficacy ratio—low toxicity, minimal side effects, useful in long-term therapy.

Side effects: Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1 to 4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

Usual adult dosage: 1 or 2 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. coated tablets.

WALLACE LABORATORIES/Cranbury, N. J.

Looking for a Place to Practice? Placement Service Lists Openings

BUREAU COUNTY: Sheffield; population 1,000. Following small towns in trade area are without physicians: Wyanet, New Bedford, Mineral, Annawan. Two physicians, ages 75 and 40. Third physician needed to replace Dr. Johnson, who died recently. Nearest physician at Princeton, 12 miles. Nearest large city, Davenport, Iowa, 50 miles. Modern air-conditioned office with air-conditioned apartment above available. Office fully equipped with latest equipment. Financial assistance could be arranged if desired.

BUREAU COUNTY: Spring Valley; population 5,000. Openings for physicians in the Illinois Valley Medical Center at Spring Valley:

"We have opened a new medical center in Spring Valley, Illinois.

The idea of a medical center in this community is new as far as this community is concerned. Three of us, Dr. R. J. Simonetta, Surgeon, Dr. P. V. Hartman, Jr., General practitioner, and Dr. Alan M. Hollett, obstetrician-gynecologist, are the nucleus. We also have a dentist, Dr. T. C. Ahnger, and a urologist, Dr. Louis Tarsines. We started the group with the idea of giving us more time off and more concentration of facilities without having to send our referrals so far away. We are in need of another general practitioner, internist, and pediatrician.

The building consisted of three floors. It is completely air-conditioned and of brick construction. We have our own laboratory and our own x-ray, with three laboratory technicians; one registered, a physiotherapist, and a registered x-ray technician. We are going to do all of our own emergency work at the center. Each doctor will have a registered nurse. We have a receptionist, one secretary for shorthand and typing, a bookkeeper, and a nurse in the pharmacy.

BUREAU COUNTY: Walnut; population 1200. Excellent opening for general practitioner. Two physicians have practiced here, not in the same office but cover for each other during vacations. After thirty years of very active practice Dr. Bolz has accepted a salaried position elsewhere, and is most anxious to find a physician to take over his large practice before September first. Figures re his practice available upon request. He and second Walnut physician cover a radius of 25 miles. The two doctors total approximately 100 deliveries annually. Nearest additional physician at Ohio, 7 miles.

Excellent hospital at Princeton, 20 miles; open staff; 110 beds; instruments available; Dr. Bolz vice-president of staff; good radiologist and pathologist at hospital; active congenial Staff; outstanding medical society.

Walnut is approximately 50 miles from tri-cities, 70 miles from Peoria, and 120 miles from Chicago. Excellent ambulance service.

Office facilities: office on second floor of building owned by Dr. Bolz on Main Street. Willing to sell building at a very reasonable figure or rent. Dr. Bolz employs an efficient nurse and secretary, who are willing to continue with new employer. Office equipment for sale if desired.

CARROLL COUNTY: Mount Carroll; population 2100. Two physicians ages 78 and 40; need for a third. Nearest hospital at Savanna, 10 miles. Nearest large city, Rockford, 60 miles. Ambulance service provided by local funeral home. New office building available; located at junction of routes 78 and 88, at edge of city limits; good parking facilities. Financial assistance could be provided.

CHRISTIAN COUNTY: Mt. Auburn; population 750. Town without a physician for several years. Four small towns in trade area without physicians. Nearest physicians at Taylorville, 17 miles, Niantic, 14 miles, Blue Mound, 12 miles and Illiopolis, 9 miles. Nearest hospital at Taylorville; St. Vincent's; 157 beds; open staff. 21 miles from Decatur; 25 miles from Springfield. New small modern office building built in 1949 available; includes reception room, rest room, examination and drug rooms. Financial assistance could be arranged for a physician.

CLARK COUNTY: Westfield; population 700. Only physician died July 1957; nearest physicians at Casey, Charleston and Kansas, 10, 11, and 18 miles. Paris Hospital; 76 beds; 22 miles. Montgomery Memorial Hospital; 32 beds; Charleston, 11 miles. Financial assistance could be given by local American Legion Post. Nearest large city, Terre Haute, Indiana.

CRAWFORD COUNTY: Palestine; population 1589. 1 practicing physician and 1 part time. New Crawford County Memorial Hospital at Robinson, 7 miles. Schmidt Hospital, 25 beds, 4 bassinets. Hospitals also at Lawrenceville, 27 miles and Vincennes, Indiana, 24 miles. Nearest large city, Indianapolis, Indiana. Seven room office for rent.

FRANKLIN COUNTY: Thompsonville; population 550. Only resident physician died several years ago;

(Continued on page 576)

test yourself

How much does the average American spend each year on these?

TOBACCO	ALCOHOL	R_x DRUGS
		
☐ $19	☐ $36	☐ $141
☐ $63	☐ $84	☐ $76
☐ $42	☐ $57	☐ $13

Score yourself 100% if you checked the bottom figure in each column. Yes, the U.S. Department of Commerce reports that 1962 per capita expenditure was $42 for tobacco, $57 for alcohol, only $13 for prescription drugs. That's about 25 cents per week per person for drugs that helped them stay well, get well, or possibly helped save their lives. Can you think of a bigger bargain?

Your patients might like to take this test, too. May we send you 25 copies for your waiting room?

Pharmaceutical Manufacturers Association — 1411 K Street, N.W., Washington, D.C. 20005

This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

Editorials (Continued from page 548)

Chromosome Studies in Leukemia

The leukemia riddle may soon be solved. There is considerable evidence that a virus is the initiating agent, especially in the acute or childhood types. We are not sure what the virus does, but there is a good possibility that it changes the genetic structure of the cells.

Reisman and his colleagues[1] from the Child Research Center of Michigan recently found a parallel between chromosome patterns and the clinical and cytologic status of 52 cases of leukemia of various types in children. Chromosome counts were performed on bone-marrow preparations. Aneuploidy was found consistently in the bone marrow during the active stages of the disease, both in the initial pretreatment phase and in relapse, months or years after the onset. These changes were not present during remission. At this only normal hematopoietic elements could be demonstrated in the bone marrow. It was their opinion that the chromosome abnormalities represent the primary disturbance in leukemia.

These conclusions might be questioned because there were a wide variety of chromosome aberrations. In addition, what initiates these changes? It is here that the virus could enter the picture initiating submicrocopic primary changes which in turn create the visible chromosome alterations. On the other hand, more basic research will be needed because there are many types of leukemia and a variety of changes are noted in different age groups. We can speculate that the initiating agent is not the same for the various forms of human leukemia.

1. Chromosome Studies in Leukemia. I. Evidence for the Origin of Leukemic Stem Lines from Aneuploid Mutants. Reisman, Leonard E.; Mitani, Muneo; and Zuelzer, Wolf W.: The New England Journal of Medicine (Mar. 19) 1964. (pgs. 591-597.)

The Colorful History of Tomatoes

The history of a vegetable that none of us pay too much attention to is very colorful. Although it is one of the most important contributions to the larder mankind, it gained acceptance first in Europe. It is believed to have been taken there by the conquistadores of Peru. During that time, much as it is today, it was fashionable to adopt the French idea of cooking.

When the tomato was brought to America, the early settlers considered it poisonous or an aphrodaisiac. The tomatoes were breeded here in 1812 but not generally accepted for eating.

The 1812 edition of the 'American Gardener' listed a recipe for tomato ketchup. Reportedly, in 1820 Col. Robert Gibbon Johnson of New Jersey ate a tomato before an awe-struck crowd to prove that it was not poisonous.

It took a United States Supreme Court decision in 1893 to classify it in its present place as a vegetable. Botanically it is considered a fruit. The Court's decision was based mainly on the fact that tomatoes are eaten with the principal part of the meal.

Before tomato juice is homogenized, it is straw-colored. It gets its red color from the particles that are suspended in it thru the homogenization process. Canned tomato juice was not available until 1928.

It is diffieult for anyone who has ever planted a small patch of seedlings and watehed them grow to realize what a colorful history this vegetable has had.

Jl. Amer Dietet. Ass'n. (Feb.) 1964. pg. 108. (Abstracted from: Proceedings of the New Jersey Historical Society 80:153, 1962. Contributed by Emma Seifrit Weigley, Philadelphia.)

PULSE
of the ILLINOIS STATE MEDICAL SOCIETY

A Service of the Public Relations Division *May, 1964*

"Roving Conference Tables" Success At Secretaries' Stint

County secretaries came away from the annual Secretaries' Conference in Springfield April 12 more enlightened than ever—thanks to an innovation called the "roving conference table."

Each table—manned by a staff member or physician expert in a particular area—was open at any time to the inquiring secretaries. As soon as their questions were answered, they could move on to other tables.

"This innovation was definitely the 'hit' of the conference," declared ISMS Secretary Dr. Jacob E. Reisch. "It gave each secretary a chance to get more of his own problems solved per unit time than any conference system used to date."

Because of its unprecedented success, Dr. Reisch declared that the roving table system might well become a permanent feature at future conferences.

Pertinent topics covered at the meeting this year included public affairs, postgraduate scientific education and dependent medical care. Delegates also mapped plans for the ISMS Annual Convention May 17-21.

The ISMS-sponsored conference is held each year to help county secretaries find better ways to serve both the public and county society members.

Premiere This Month



NOT BY BREAD ALONE—is title of new ISMS Medicine-Religion Committee film which will premiere at Annual Convention May 19. Among the "stars" are from left, Father John Marren; Rabbi Nathan Weiss; Mr. Claude Hoff; and Dr. Joseph Skom. The film—which demonstrates serious consequences when physicians and clergymen do not work together—will be distributed to county societies to stimulate formation of Medicine-Religion committees at the local level.

Secretary Award



Among seven recipients of the "ISMS County Secretary Award" presented at Secretaries' Conference April 12 is Dr. Karl Dexter Nelson left, of Princeton, here receiving personal congratulations from Dr. Jacob E. Reisch. Other award recipients were Dr. Eugene P. Johnson, Clark County; Dr. M. H. Parker, Clay County; Dr. Stanley W. Theil, Coles-Cumberland County; Dr. Elmer T. Swann, Henderson County; Dr. John E. Bohan, Mercer County; and Dr. Howard J. Stickle, Stephenson County.

Dr. Piszczek Made Honorary Public Health Member

ISMS President-elect Dr. E. A. Piszczek has received official kudos on his election to honorary membership in the Illinois Public Health Association.

A congratulatory letter from Dr. Franklin D. Yoder, director of the Illinois Department of Public Health, states, in part:

"I would like to take this opportunity of congratulating you upon your award of Honorary Membership during the annual meeting of the Illinois Public Health Association.

"This is a fine recognition of your contributions to the public health of the great State of Illinois."

Fifty Years of Service



The pride of his son is obviously enjoyed by Dr. Clarence H. Boswell of Rockford, center, upon his initiation into the "Fifty Year Club" of the Illinois State Medical Society. Rockford surgeon Dr. William B. Boswell, left, took part in the testimonial dinner program conducted for his father by the Winnebago County Medical Society. Doing the honors of presenting the ISMS award is Dr. William K. Ford, Winnebago County's president-elect.

DR. CALLAHAN HEADS IAP

Dr. George B. Callahan, Waukegan, took the helm as first president of the Illinois Association of Professions last month.

Election of the inaugural slate officially launched the organization, which represents the Illinois State Medical Society, Illinois Dental Society, Illinois Bar Association, Architects Association of Illinois, Illinois Pharmaceutical Association, Illinois Society of Professional Engineers and the Illinois Veterinary Medical Association.

An outstanding leader in ISMS affairs, Dr. Callahan is also Chairman of the Liaison Committees to the Illinois Pharmaceutical Association and the Illinois Association of the Professions. He is a past regent and currently vice-regent of the International College of Surgeons, trustee of the Interstate Postgraduate Medical Association of North America, chairman of the Chicago and Northern Illinois Committee of the World Medical Association, and Lake County representative to the House of Delegates of the Illinois State Medical Society.

Named executive director of the IAP is Robert L. Richards, executive administrator of the Illinois State Medical Society.

The Illinois Association of Professions represents some 50,000 professional people in the state.

Special Radio Series on Tetanus, Smallpox

"Tetanus kills when you don't care."

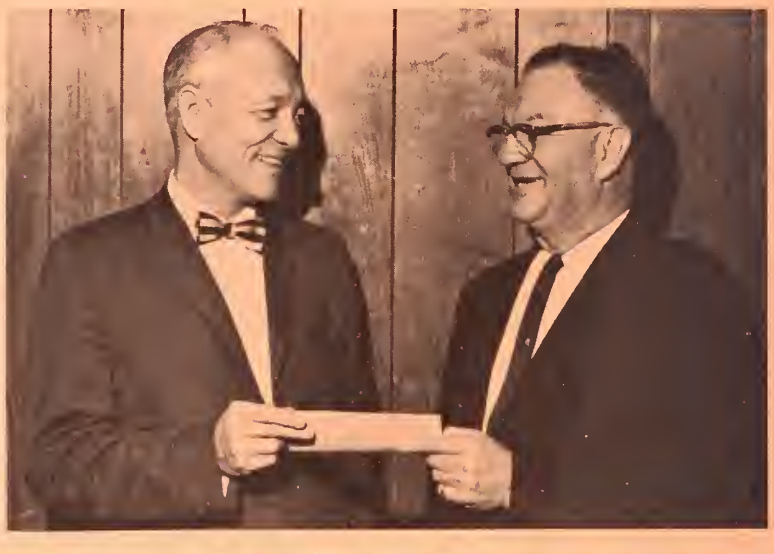
This ominous warning introduced a special series of ISMS-produced health messages to WJJD listeners last month.

Four times daily for seven days, the Des Plaines-based station rotated 30-second and one minute announcements urging the public to protect itself from the ravages of tetanus through immunization. The special announcements featured ISMS past president Dr. George F. Lull, whose daily "Health Tip" messages have been heard more than 1,000 times on WJJD.

To kick off the week-long series, Dr. Lull teamed with Dr. Donald A. Dukelow, Assistant Director of Community Health and Health Education of AMA, as guest on the 10-minute WJJD interview show "Let's Talk It Over."

A similar series on smallpox is being planned for broadcast on WJJD later this month.

Support Educational TV



Dr. Edward Piszczek, President Elect of the Illinois State Medical Society, right, presents $1,000 check to Dr. John W. Taylor, executive director of WTTW/Channel 11, as a contribution to the 1964 fund drive in support of educational television. In accepting the donation, Dr. Taylor stated, "The Illinois Medical Society and WTTW have always worked closely together in past years both in the production of programs and in the furtherance of education in the scientific fields. This additional evidence of their support is greatly appreciated."

ISMS On Health Exhibit Team

ISMS and the Chicago Nutrition Association teamed up to present the society's "Essentials in Dieting" exhibit in the Chicagoland Health Fair.

Members of the association manned the exhibit from April 23 to May 3 at the Museum of Science and Industry, marking the first time that ISMS offered its display in cooperation with another organization.

President of the association of 200 nutritionists, dieticians and food scientists is Dr. Ogden Johnson, who is also associate director of the Department of Foods and Nutrition of the American Medical Association.

Manpower provided by the joint effort permitted the use of a physician's scale and "weight and height guide chart" to complement the exhibit's visual and pre-recorded messages.

Prime Time Slot For Medically Speaking

"Medically Speaking," ISMS' new half-hour TV interview show presented over UHF Channel 26 in Chicago, now enjoys the prime time slot of 7:30 to 8:00 p.m. every Monday evening. The show moved from its original time slot of 4:30 to 5:00 p.m. every Monday on May 4.

Auxiliary Rewriting Record Book in HC Recruitment

As a member of the Board of the Health Careers Council of Illinois, the ISMS Auxiliary is assisting in Health Careers Conferences all over the state.

Here are the results to date: The Health Careers Council of Illinois has conducted six county-wide Health Careers Conferences; has participated in twelve Careers Day Programs in individual schools, a Careers Carnival at Western Illinois University and the annual Careers for Women's Day Conference; and has fulfilled 345 individual requests for health career information. It has nine more county-wide Health Careers Conferences scheduled for the months of April and May.

In the completed program over 2,000 students from 79 high schools and nearly 500 high school guidance personnel have been given an opportunity to learn first-hand the opportunities and rewards of health careers. Estimated student attendance for the nine county-wide conferences of the next two months is 3,600.

Experience gained in conducting previous conferences has been used to produce a 35-page instruction manual on planning and conducting these Health Careers Conferences. The manual is being used in program development training sessions with medical auxiliaries throughout the state. Letters have been sent to all presidents of county medical societies informing them of this project.

There are requests made for starting Health Careers Clubs in the high schools. We now have over fifty clubs (including Future Nurses Clubs) in the state. If your county has no club, please contact the Health Careers Chairman of the Illinois State Medical Society for information on starting one. These can be of great value in acquainting both boys and girls with the opportunities available and the great number of fields in Health Careers.

The report of the Health Careers Chairmen, with thirty counties reporting, show that thirteen counties offer scholarships in the amount of $6,420 and loans are offered in seven counties in the amount of $2,025, most of which are in the field of nursing.

(Continued on next page)



Auxiliary Health Careers Conference in Moline April 18 attracted more than 80 students from Quad City area. Here, Dr. Thomas Grevas, President of the Rock Island County Medical Society, advises two students on opportunities in health careers. Chairman of the Conference—which was sponsored by R.I. County Society Auxiliary—was Mrs. Virginia Mencarow.

A Challenge For County Societies

This year ISMS is presenting the first Journalism Awards Competition in its history. Open to all radio and TV stations and newspapers in the state, it will award citations for outstanding achievements in communications which contribute to a closer understanding between the medical profession and citizens of Illinois in 1964.

Success for this program is a challenge to county medical societies; it is upon them that local media rely to obtain medical news of interest for the citizens they serve. To make certain that sufficient news is relayed and used to make entry in this competition worthwhile, county societies are urged to: (1) FORM committees to maintain close liaison with local media; (2) MAKE AVAILABLE to local radio and TV stations a list of speakers willing to appear on discussion and interview shows; (3) INFORM your media of important medical activities, such as immunization drives, health fairs, etc.; (4) SHOW a willingness to cooperate in interview requests; and (5) SUGGEST special features of medical interest.

Hints and help on programming—as well as an awards announcement to familiarize county secretaries with the details of the program—are available by writing to ISMS Headquarters, 360 N. Michigan Ave., Chicago, Illinois, 60601.

Your acceptance of this challenge will do more than assure success of the first journalism awards competition in ISMS history—it will help to establish an even closer bond of understanding between the physician and the public in your local community.

Leo P.A. Sweeney M.D.

Chairman, Committee on Public Relations

AUXILIARY NEWS

EDITOR
Mrs. Oliver Veneklasen
ASS'T EDITOR
Mrs. Theodore Proud

Continued from preceding page

HC Recruitment

We have available LIST OF PAMPHLETS and SOURCES OF SCHOLARSHIPS which can be given to counselors in our high schools, to ministers who do some counseling, or placed in public libraries where students go for information.

Certainly, the doctor and his wife should take the lead in getting qualified young people interested in a Health Career. Let's show the community that we are interested not only in encouraging young people to go into these fields to provide the needed personnel for the expanding health needs, but also stand ready to help them with scholarships, loans and encouragement and personal interest along the way. Our rewards WILL be great!

Mrs. Alden Rarick
Chairman, Health Careers Committee

Teens To Meet East, West At AMA June Convention

Arranged by the Woman's Auxiliary to the AMA, the teenagers' program starts Sunday, June 21, with a 1 p.m. ice skating party at Sutro's, a local amusement park.

On Monday, a walking tour of Chinatown, a visit to a fortune cookie factory and lunch at the Four Seas Restaurant are on the schedule.

At 2:30 that afternoon, there will be a cable car ride to Fisherman's Wharf, then a cruise of San Francisco Bay.

A five-hour bus excursion to the San Francisco Zoo, Steinhart Aquarium, Japanese Tea Garden and other points of interest will begin at 9:30 a.m. Tuesday.

At 4 p.m. Tuesday, teenagers will gather back at the St. Francis Hotel for a hootenanny and refreshments, free of charge.

The program winds up Wednesday with visits to the Tennessee Ernie Ford and Dick Stewart television shows.

Your Entertainment Itinerary...
FOR THE '64 ANNUAL MEETING

TUESDAY, MAY 19

At Sherman House' George Bernard Shaw Room, Mrs. William H. Evans, President Elect of the Woman's Auxiliary to the American Medical Association, will be honored speaker of the morning. Her topic: "The Doctor's Wife in a Changing World." Tuesday evening will be a memorable one... with a dinner party at Martinique Restaurant, followed by the show "Claudia," featuring Jeanne Crain at the Drury Lane Theatre. Buses leave Sherman House Hotel at 5:30 p.m.



Mrs. William H. Evans



Mrs. Haven Smith



Mrs. Thomas W. Carter

WEDNESDAY, MAY 20

"Out at the Chimney," is the entertaining feature presented immediately after a Continental Breakfast in the George Bernard Shaw Room by Mrs. Barbara Carter, Publicity Chairman for the Auxiliary Convention. Following Round Table discussions, Mrs. Haven Smith, National Chairman, American Farm Bureau, will tell conventioneers why "We're In This Together." Highlight of the entire Convention takes place Wednesday evening at the Annual Dinner in Sherman House' Grand Ballroom.



Miss Sulie Harand



Dr. and Mrs. Howard Reiser

THURSDAY, MAY 21

Pedis Frigidi," a sound, color movie produced by Dr. and Mrs. Howard Reiser, Joliet, will be shown after breakfast in the George Bernard Shaw Room. The film—which lampoons its way through medical history with a few jabs at organized medicine—is presented in cooperation with the Woman's Auxiliary to the Will-Grundy Medical Society. The meeting will close on a delightful musical note supplied by the noted entertainer, Miss Sulie Harand. Miss Harand will present her inimitable, cast-of-one presentation of "The Sound of Music."

NEWS and ANNOUNCEMENTS



Announcements

New Academic Medicine Program at Northwestern

Northwestern University, already making it possible for exceptional students to earn an M.D. degree in six years, is now designing a Medical Scientist Training program that will enable talented students who are interested in research and teaching to earn both the M.D. and the Ph.D. degrees in nine years. At present, students are normally required to spend an average of eleven years earning the same degrees. Five students who have completed their second year in Northwestern's Medical School will be admitted to the new program each year, beginning in June, 1965.

The new program will be supported with grants from the National Institutes of Health. The Institutes' division of General Medical Science has awarded Northwestern $328,000 to support the program over the first three years.

Students in the medical science program will receive full tuition scholarship and annual stipends. In this way, Northwestern hopes to attract outstanding students, who otherwise might not be able to afford the extra years of preparation required to earn the Ph.D., to careers in medical research and teaching.

Students who qualify for the new program will take a leave of absence after completing their second year of Medical School and enter the University's Graduate School. Here they may earn the Ph.D. in a basic medical science (such as biochemistry) in a minimum of three academic years. They will then resume Medical School training and will earn the M.D. degree in two additional years.

Dr. J. B. Kahn, Jr., professor of pharmacology, will serve as director of the new program. Co-directors will be Dr. Allen Lein, professor of physiology; and Dr. John A. D. Cooper, Dean of Sciences.

"The need for top students to enter academic medicine is greater than ever before," said Dr. Kahn. "More and more research is being done in the basic sciences of medicine and, as medicine becomes more scientific, it takes more doctors trained in science to do research in it and teach it."

Research On Antibodies By Dr. Kurt Stern

"Animals which have formed antibodies to combat antigens in red blood cells different from their own appear to be less likely to form antibodies for, or become immunized to, other antigens in the same kind of red blood cells." This statement was made by Dr. Kurt Stern, professor of pathology at the University of Illinois College of Medicine in Chicago. Under a $12,600 grant from the United States Public Health Service, Dr. Stern and Milton Farquhar, a medical technologist, are continuing a study which Dr. Stern began several years ago on "Isosensitization Caused by Pregnancy or Transfusion."

"Difficulties in blood transfusions are frequently caused by differences between antigens in the red blood cells of the blood donor and in the patient," Dr. Stern continued. "The patient may react to these differences by producing special proteins, called antibodies, which can destroy the red cells with the 'foreign' antigen."

Similarly, a pregnant woman may form antibodies for some 'foreign' antigen in the blood of her baby, Dr. Stern explained. This may cause serious damage to the blood and sometimes death for the child.

Under certain conditions, these antibodies are not formed. "Our work is concerned with defining such conditions, especially in relation to the combination of various antigens in red cells of the recipient and donor of blood."

(Continued on page 566)

(Continued from page 565)

During the past three years, Dr. Stern has been studying these problems in rats and rabbits. The animals are injected with red cells of other animals with consideration of whether or not one or more 'foreign' antigens are present. "In some experiments, the formation of 'new' antibodies was prevented , apparently because 'old' antibodies, remaining from an earlier immunization, successfully competed for the injected red cells."

"We measure these processes by delicate tests, including the use of red cells which have been made radioactive." Dr. Stern concluded.

American College of Surgeons Donates Books

The American College of Surgeons has presented seven new medical schools in the United States with a gift of 12,345 volumes of scientific journals and 752 textbooks.

"Allocation to these new medical schools was made because the College's board of regents felt that medical students attending these new schools could profit most from the generous donation," said Dr. John Paul North, Chicago, director of the ACS. "These materials," he added, "will form a valuable nucleus for their own new libraries."

The board of regents voted to dispose of these materials when the College's library was recently changed to an historical collection, with particular emphasis upon American surgery, Dr. North said.

Medical school recipients, and the total number of volumes they received are: University of Arizona, Tucson, 1,192; Brown University, Providence, 2,432; Albert Einstein College of Medicine, New York, 319; University of Kentucky, Lexington, 2,881; University of New Mexico, Albuquerque, 2,556; Seton Hall College of Medicine and Dentistry, Jersey City, 589; and West Virginia University, Morgantown, 3,127.

Chest Physicians Plan Mexico Congress

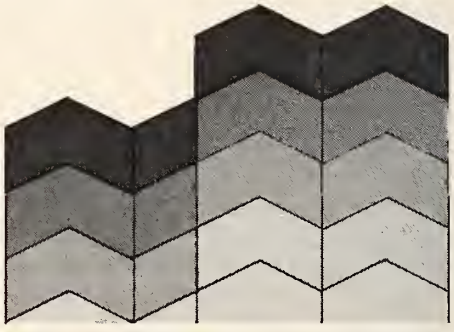
Physicians from more than 50 countries will present papers and discuss the recent advances in cardiovascular and pulmonary diseases at the VIII International Congress on Diseases of the Chest to be held in Mexico City, October

(Continued on page 567)

of all oral corticosteroids:

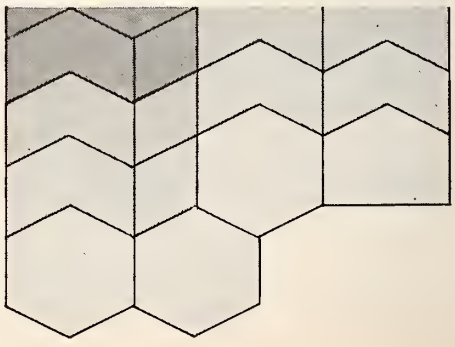


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(Continued from page 566)
11-15, 1964.

Doctor Donato G. Alarcon, Dean of the Medical School at the University of Mexico and Professor of Thoracic Diseases, is the President of the Congress. Doctor Ignacio Chavez, President of the University of Mexico and Professor of Cardiovascular Diseases, is Vice-Chairman.

The Honorable Adolfo Lopez Mateos, President of the Republic of Mexico will officially open the Congress on Sunday, October 11th.

All physicians are invited to attend this important Congress. For further information and registration blanks write to the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

Four Billion Dollars Spent Under Hill-Burton Program in 15 Years

Between 1948 (when the first state plans under the Hill-Burton Program were submitted) and 1963, the total volume of construction under the Hill-Burton Program was $4 billion, or an average of $270 million annually. This $4 billion was 31 per cent of the nation's total spending for hospital construction during the 15-year period.

In 1962, $511 million was spent under the program. Of this total, the sponsor's (non-federal) share was $327 million, or 64 per cent. Federal share was $184 million.

As of November 30, 1963, a total of 6,975 projects had been approved for federal aid under the Hill-Burton Program. Of this total, 5,648, or 81 per cent, were completed. The remaining 1,327, or 19 per cent, were under construction or in the planning stage.

The 6,975 approved projects will provide 296,735 in-patient beds, the bulletin said. In addition, they will provide 1,968 health facilities, such as laboratories, diagnostic centers, and rehabilitation centers. By December 31, 1962, 202,888 beds were actually completed. This was 12 per cent of the nation's total in-patient beds at that time.

Other significant accomplishments of the program have been (1) systematic statewide planning for hospital facilities, (2) development of standards of need, (3) better distribution of facilities, and (4) improvement of hospital design and operation.

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1. Ringler, I., West, K., Dulin, W. E. and Boland, E. W.: Metabolism 13:37, 1964.
2. Black, R. L., et al.: Arthritis and Rheumatism 3:112 (April) 1960.

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—Lucia, S. P.: "Wine as Food and Medicine," New York, The Blakiston Company, Inc., 1954.

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American Cancer Society Sponsors Anti-Smoking Conference

In keeping pace with the accelerated attack that is aimed at reducing the alarming increase in death rates from lung cancer, the American Cancer Society, Illinois Division, is sponsoring a working conference entitled, "Helping the Adult Smoker to Stop Smoking." The conference will be held on Monday and Tuesday, April 13 and 14, at the Institute of Medicine of Chicago.

The objectives of the conference are: (1) To share clinical experiences in helping the adult smoker stop smoking, (2) To identify major problem areas in regard to the physician-patient relationship concerning smoking, (3) to assess the practicality of preparing clinical guidelines for physician use in counseling the smoking adult who wants to or must stop smoking, and (4) to assess the practicality of preparing supportive material for the patient.

From Capitol Hill

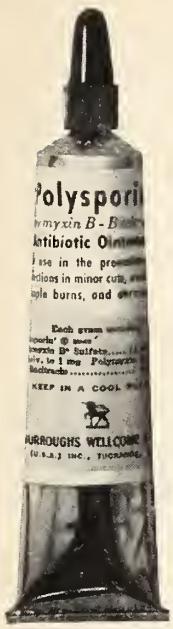
Government Drug Regulations Reflect Pharmaceutical Industry's Policies

New government regulations on prescription drugs reflect, for the most part, quality and safety controls which the pharmaceutical industry has developed, Austin Smith, M.D., president of the Pharmaceutical Manufacturers Association, said in Congressional testimony today. Dr. Smith testified before the House Subcommittee on Intergovernmental Relations. This committee is exploring how effectively the Food and Drug Administration is administering the new drug law, and also whether a proper balance is maintained in weighing the usefulness of new drugs against their possible hazards. Subcommittee chairman is Rep. L. H. Fountain (D.-N.Car.).

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(Continued on page 570)

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(Continued from page 568)

everything possible to make sure that they know what the drug will do and that they have the evidence to justify its marketing," said Dr. Smith. Commenting on the administrative burden of FDA, Dr. Smith said that the agency is called upon "to administer not only the laws of man, but the laws of science as well."

Dr. Smith's Recommendations

The PMA president made these seven recommendations for greater success in this quest in the public interest:

1. Strengthen the FDA staff, facilities and organizations, in part through provision of adequate Congressional appropriations and salary levels for personnel.
2. Implement speedily the recommendations of a Citizens Advisory Committee calling for, among other things, the establishment of a National Food and Drug Advisory Council modeled after the various councils to the National Institutes of Health.
3. Establish scientific advisory panels to assist FDA on technical issues involving the safety and effectiveness of new drugs.
4. Establish a Council for Scientific Review to provide for appeals on drug evaluation problems.
5. Establish a joint Government-Industry Board to advise the Commissioner of Food and Drugs on a system of reporting on safety and efficacy of drugs.
6. Publish periodically detailed reports on medical research projects supported by the federal government.
7. Improve communication between FDA and the drug industry on regulatory matters, including plans for new regulations.

Dr. Smith emphasized that communication and cooperation between government, industry and the medical profession is of paramount importance, but that the functions of these groups must remain distinct.

"The manufacturer should make a good product, the government should see that the product complies with the law, and the physician should select the product and determine how to use it for his sick patient," he added.

Dr. Smith emphasized that achievement of

(Continued on page 572)

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(Continued from page 570)

absolute drug safety is dependent on gaining more knowledge of the chemistry of body cells. We know that a certain drug works in a certain way, he said, but often cannot explain why.

"The object of the drug researcher is not to placate or please, to avoid controversy, or shun possible lawsuits," he declared, but rather to pursue the "acquisition of new knowledge, the finding of new cures, and the solving of some of the more stubborn mysteries in the health field."

The average time between discovery in a research laboratory and the time when a drug is finally marketed is five to six years, said Dr. Smith. The cost of developing a single new drug is estimated to average six million dollars. The number of quality control experts amounts to about 20 per cent of the total number of industry production employees.

Accomplishments of U.S. Drug Industry

Dr. Smith reviewed the following significant accomplishments of the U.S. drug industry:

1. Of more than 500 major new drugs made available in the U.S. since 1941, nearly two-thirds originated in this country.
2. More than 4,000,000 Americans living today would be dead if the 1937 death rate had continued.
3. The industry has spent more than $2 billion on research and development since World War II.
4. In 1962, the industry screened about 160,000 substances, studied the effects of drugs on nearly nine million animals, and selected 1,300 substances for the additional painstaking process of clinical testing. A total of just 28 basic new drug substances was placed on the market that year.

Environmental Health Hazards

There is a growing concern about the relationships between environmental pollution and disease. Sen Edmund Muskie (D-Me.) warned the automobile industry that he is maintaining a careful watch on the industry's announced plans to put smog control devices on 1967 model cars destined for sale in California.

(Continued on page 573)

(Continued from page 572)
"Vehicle exhaust," says Muskie, "must be curtailed if any real progress is to be made in obtaining clean air."

And the speeches about environmental health hazards continue. US Surgeon General Luther L. Terry has expressed concern about the "chemicalization of our environment." Speaking at the dedication of a new laboratory devoted to environmental health studies, Terry noted that "Every year, more than 500 new chemicals and chemical compounds are introduced." He went on to state that there is often a time lag before the harmful effects of these compounds is noted.

New Pressure on Amphetamines Bill

A campaign has been mounted to get action started on new amphetamine-barbiturate legislation. New bills—S.2628 and H.R.10409—have been substituted for legislation that has been before Congress for some time—with no progress.

Two changes were made. First, the definition of dangerous drugs that appeared in the Report of the President's Commission on Narcotics and Drug Abuse was substituted for the previous language. Second, a new section authorized FDA investigators to carry guns. The major change in definition is the provision bringing under the scope of the bill "any drug which contains any quantity of a substance which the (HEW) Secretary, after investigation, has found to have, and by regulation designates as having, a potential for abuse that may result in psychotoxic effects or antisocial behaviour."

Americans Are No Longer the World's Healthiest People

According to a USPHS publication entitled, "The Change in Mortality Trend in the United States," there has been no improvement in the American death rate for the past 10 years. Nor is it expected that the US death rate will soon be cut down to the level enjoyed by the people of Japan, the Scandinavian countries or the Netherlands. Today, these are the healthiest nations in the world.

The US death rate declined steadily until it

(Continued on page 574)

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Fractures & Traumatic Surgery, Two Weeks, June 8
Gynecology, Office & Operative, Two Weeks, June 8
Vaginal Surgery, One Week, June 22
Obstetrics, General & Surgical, Two Weeks, July 13
Board Review Course in Gyn-Ob, Two Weeks, October 26
Fluids & Electrolytes, One Week, August 17
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(Continued from page 573)
hit a bottom plateau in 1954. Since then, it has remained steadily at this low point. Until the latest USPHS report was issued, Asian flu epidemics has been blamed for the "status quo" in the current mortality rate. The USPHS now claims, however, that failure to make progress against chronic and degenerative diseases is probably the principal reason why the death rate has remained stagnant for the past decade.

The report points up the rather shocking fact that we are no longer the healthiest people in the world. "After a long period of rapid and substantial decline," the report states, "the death rate for the US has reached the point where further decreases as experienced in the past cannot be anticipated." Such an admission by USPHS becomes all the more alarming when one considers how our expenditures for medical care and research have skyrocketed during the past 10 years.

Upon further questioning, USPHS spokesmen admit, however, that the reasons why we have not become a healthier nation could very well be associated with *radioactive fall-out, air pollution,* and other *man-made hazards.* The solutions to problems linked with such factors are, in the last analysis, the primary responsibility of the USPHS.

Research Notes

New Antibiotics Tried in Cancer Therapy

Clinical investigators have reported varying degrees of success in treating certain cancer patients with two new antibiotic drugs—*mithramycin* and *streptonigrin.*

Mithramycin has been under clinical investigation for more than two years. During this time it has been tried against a variety of human cancers. It is, however, classified as an experimental drug. As such, its use is restricted to certain qualified clinical investigators.

One such qualified clinical investigator is Dr. Sydney Kofman, of Presbyterian-St. Luke's Hospital and the University of Illinois College of Medicine, both of Chicago, Illinois.

More than 100 patients were treated with mithramycin in Dr. Kofman's series. Although about 30 per cent of these patients showed some evidence of initial improvement, the benefits of mithramycin therapy were of relatively short duration in most instances. Worthwhile improvement was, however, maintained for periods of more than six months in nine cases.

The most encouraging results were obtained in patients who had embryonal cancer. This is an undifferentiated tumor which is noted for its rapid growth, and for its tendency toward early spread to other parts of the body. Four patients with embryonal cancer are still maintaining tumor regressions after periods of from eight to 25 months. Four other patients with embryonal cancer showed significant, but transient, tumor regressions.

Dr. Kofman noted that about one-third of the patients who had metastatic tumors of the brain showed improvement. True, this improvement was of short duration in most cases. However, control of neurological symptoms was maintained for over eight months in at least three cases.

As with almost all other anti-cancer drugs, side effects limit the dosage of mithramycin. These side effects have been minimized to some

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extent by technique improvements worked out by Dr. Kofman. Thus far, however, the usefulness of mithramycin appears to be limited to the treatment of certain types of cancer—particularly to the undifferentiated types known as anaplastic cancers.

A research team at the New York University Medical Center has reported some progress with the use of streptonigrin in the treatment of some cancers. This team is composed of Drs. Matthew N. Harris, Theodore J. Medreck, Frederick M. Golomb, Stephen L. Gumport, Allen H. Postel, and Jane C. Wright.

One streptonigrin study was carried out to evaluate four possible routes of administration of the drug. These routes were: Oral, continuous intravenous infusion, continuous intra-arterial infusion, and isolation perfusion. The method of administration was, in each case, determined by the location and the accessibility of the tumor and also by its biological nature.

A total of 80 patients were evaluated in this study. Objective responses—meaning a significant reduction in tumor size—was seen in 31 cases (39 per cent). The best results were observed in 12 patients who had malignant lymphomas. Five of seven patients with mycosis fungoides (a cancer primarly involving the skin), showed definite therapeutic benefits for varying lengths of time.

As with mithramycin and other anti-cancer drugs, the side effects encountered with streptonigrin presented a dosage problem. The principal side-effects noted were a depression of blood cells and gastro-intestinal disturbances.

Errata

Notices to the Illinois State Medical Society, reporting the "deaths" of Drs. Herbert B. Henkel, Springfield and Francis C. Sedlak, Cicero, appeared in the April issue, *Illinois Medical Journal*. Both physicians called the ISMS office to assure us that they were in excellent health. They wished that their friends and fellow society-members be so advised. We are most apologetic to Drs. Henkel and Sedlak. We hope that the items caused a minimum of embarrassment to them.



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Deaths

Adolph R. Cinelis*, Marengo, was a graduate of Scientific Medical College in 1940 and an Army officer during World War II. He died March 20, aged 52.

Carl C. Dillon*, Sidell, died January 8, aged 84. In 1906 he was a graduate of Illinois Medical College.

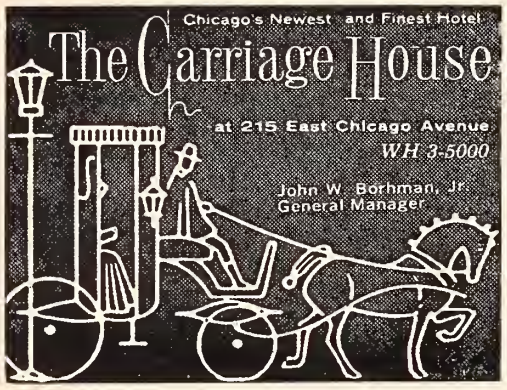
Erasmus M. Hill*, Chicago, died April 2, aged 94. He was a graduate of Rush Medical College in 1894.

Robert S. Jordan*, South Holland, died April 11, aged 45. In 1942 he was a graduate of Indiana University School of Medicine and was plant physician at the United States Steel South Works.

Edward L. Larson*, Wheeling, died April 1, aged 81. He was a graduate of Loyola University Medical School in 1914 and retired to Florida in 1960. He was also a veteran of the Spanish-American War.

Julian M. Tobias, Chicago, died April 12, aged 52. He was a graduate of Johns Hopkins in 1937 and a specialist in neurophysiology. He had been a professor at the University of Chicago since 1942 and was the author of over 50 papers dealing with his specialty.

**Indicates member of Illinois State Medical Society.*



Places to Practice

(Continued from page 558)

Nearest physicians at West Frankfort and Benton, 10 and 12 miles. Franklin Hospital at Benton. U. M. W. H. Union Hospital, West Frankfort, 38 beds. 115 miles from St. Louis, Missouri.

FULTON COUNTY: Table Grove; population 500. Adair, population 400, 6 miles north, also without a physician. Nearest physicians at Ipava and Vermont, 7 miles and 5 miles distant. Only physician retired in 1954. Three hospitals at Macomb, 17 miles. Nearest large city, Peoria, 65 miles. Population 100,000.

GALLATIN COUNTY: Equality; population 1000. Last physician died several years ago after practicing here for 50 years. 12 miles from Ohio River. Town supported three physicians at one time. Nearest physicians at Eldorado and Harrisburg, 8 and 12 miles. Hospitals in Eldorado and Harrisburg; 200 beds. Citizenship required for hospital staff membership. Population of Eldorado, 5800.

LAWRENCE COUNTY: Lawrenceville; population 6800. Several small towns in trade area without physicians—Sumner, St. Francisville, Flat Rock and Birds. Lawrence County Memorial Hospital located here. 70 miles from Evansville, Indiana. 3 prescription drug stores. Office space and housing available. Financial assistance could be arranged.

LAWRENCE COUNTY: St. Francisville; population 1040. Town without a physician since June 1962. (Only physician died) Nearest physicians at Vincennes, Indiana, Lawrenceville and Mt. Carmel. Nearest hospital at Lawrenceville, 12 miles. Nearest large city—Evansville, Indiana, 63 miles. Financial assistance could be arranged.

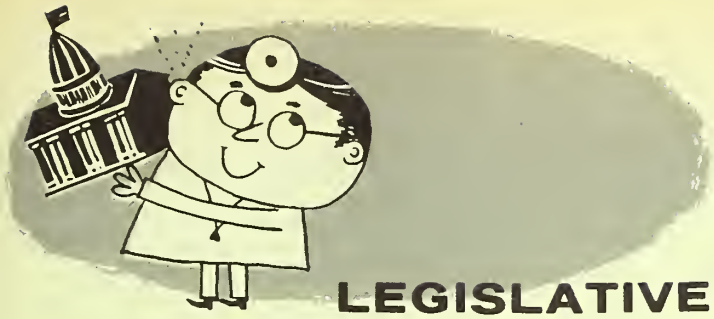
LaSALLE COUNTY: Marseilles; population 5,000. Richard F. Dunn, M.D. plans to vacate his offices in Ottawa and Marseilles in order to devote full time to industrial medicine. Offices are 8 miles apart. 3 physicians in town. Nearest hospital at Ottawa, Ryburn Memorial, 8 miles. Two prescription drug stores.



a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

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LEGISLATIVE LISTENING POST

June, 1964

ILLINOIS CONGRESSMEN ACT TO AMEND CONSTITUTION

Illinois Congressmen Anderson, Derwinski, Henley, Michel, Reid, and Shipley, have each introduced legislation to amend the Constitution of the United States to permit prayers and Bible reading in the public schools. The House Judiciary Committee continues hearings on the 160 bills that have been introduced on this subject.

PHYSICIANS SUBJECT TO ANTI-TRUST AND MONOPOLY INVESTIGATION

The Senate Subcommittee on Anti-Trust and Monopoly is continuing its investigation of drug re-packaging firms which have physicians as large stockholders, and is continuing its inquiry concerning the legality of physician-owned pharmacies.

A report of the Subcommittee states, "To the (independent) pharmacist, this presents an economic problem involving possible monopolization of their field of endeavor in presenting them with a competitive situation with which it is difficult to cope because of their total dependence on the prescribing physician."

PERCY PURGE PURIFIES PARTY

Republican State Nominating Convention on June 1 supported the slate of 118 candidates for the state legislature selected by the forces of Percy, Scott and Ogilvie. The "blue-ribbon slate" scotches the political ambitions of Peter Miller, Walter McAvoy, Peter Granata, Louis Capuzi, Robert Austin, and W. J. Murphy. These men were denied renomination because of relationships with the so-called West Side Bloc. Percy said that the slate of 118 candidates "warrants the support of all good Republicans."

DEMOCRATIC NOMINATING CONVENTION DEFERS ACTION

Meeting on June 1 the Democratic state nominating convention recessed after selecting a 21-member executive committee to slate its 118 state legislature candidates. The executive committee consists of 8 members from Chicago, 3 from suburban Cook County, and 10 from Downstate. The Convention will reconvene about June 15 to consider and to nominate the slate of candidates.

HILL-BURTON ACT -- HOUSE TO SENATE

Without a dissenting vote, the House of Representatives has approved the expansion and extension of the Hill-Burton Act for another five years. The bill which was sent to the Senate authorizes the federal government to spend more than 1.4 billion in the next five years to help build modernized hospitals and other medical facilities. Several Congressmen praised Hill-Burton as an excellent example of federal-state cooperation.

U.S. GOVERNMENT REPORTS MEDICAL COST INCREASE

The March and April Consumer Price Index of the Labor Department reflect a 2% and .3% rise in medical care to 119.0 of the 1959 base of 100. The 2.3% increase for two months was attributed by the Department to higher fees for professional and hospital services. Chicago with an index of 127.5 was one of several cities that showed significant increases. Health care for which a Chicagoan paid $100 in 1959, cost him $127.50 in April 1964.

OSTEOPATHS STRADDLE THE HEALTH CARE ISSUE

The president of the American Osteopathic Association speaking at the college of Osteopathic Medicine and Surgery in Des Moines, Iowa stated that the association would not take a stand for or against the King-Anderson Bill. Wallace Pearson, D.O., asserted however, that the AOA is vitally interested that the medically indigent aged are assured of health care.

WHEN ILL - CHIROPRACTORS PREFER M.D.'s

Dr. Reinert Ravenholt of the University of Washington reports that chiropractors seem to prefer the services of M.D.'s when they are seriously ill. Records of 242 California chiropractors disclosed that 44% of the chiropractors had died in medical hospitals and that only 3% of the death certificates had been signed by other chiropractors. Dr. Ravenholt states, "These figures provide a measure of the chiropractor's regard or lack thereof for the work of his colleagues. Apparently very few chiropractors seek diagnosis treatment from their associates when they have discovered that they are seriously or internally ill."

WHEN TRUTH IS PUBLISHED - CHIROPRACTORS SUE

District Court Judge Cassibry dismissed a chiropractor's $500,000 libel suit against the Louisiana State Medical Society. Chiropractor claimed that a LSMS pamphlet "Your Doctor Defines the Facts and Fallacies of Chiropractic" caused him to lose business as it contained libelous statements. The court noted that no chiropractor was identified and that the statements in the pamphlet were not proved to be false.

IMJ

Illinois Medical Journal

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PRESIDENT'S EMBLEM is bestowed on Dr. E. A. Piszczek, right, by outgoing president Dr. Harlan English.

Convention '64...

NO MATTER how you looked at it, the 124th Annual Convention of the Illinois State Medical Society May 17-21 was big—big in concept, big in scope, big in achievement.

Beginning on an international note, it heard a Belgian physician discuss events leading to the now-famed "doctors' strike" of that country.

It boasted an association with such famous names as former U. S. Representative Walter H. Judd; Senator Roman L. Hruska of Nebraska; baseball great Stan Musial; television personality Alex Dreier; and AMA Scientific Director Dr. Hugh H. Hussey.

It set a new and unprecedented record for radio, television and newspaper coverage.

It incorporated the annual meeting of the Illinois Surgical Society; Illinois Society of Ob-Gyn.; Illinois Physicians' Association; Illinois Society of Internal Medicine; Illinois Academy of General Practice; Illinois Society of Pathologists; Illinois Academy of Pediatrics; and Illinois Chapter, American College of Chest Physicians.

It premiered activities of three new ISMS operations.

It drew more than 3,000 physicians, guests, speakers, exhibitors and Auxiliary—matching last year's record and topping the attendance record of two years go by 40 per cent.

Above all, it accomplished the ponderous and sometimes overwhelming task of determining the policies and selecting the men who will carry the banner for the medical profession in Illinois through 1964-5.

For those who were unable to attend, or whose stay was too brief to see it all, here is a summary wrap-up of Convention '64:

vital messages in a critical year

In this politically significant year, there is

GREAT EXPECTATIONS are awaited by "Full House" of Delegates at opening session Sunday evening, May 17. During three hectic sessions, House voted on 24 Resolutions plus lengthy Reference Committee Reports from six ISMS divisions, also elected new officers and trustees. Approved House actions become ISMS "law of the land" for at least another year.





ON THE AIR is Dr. Joseph J. Farber of Brussels, Belgium, right, who addressed opening session of House to describe Belgian "doctors' strike." Interviewer is Dr. Burton Winston, whose weekly 15-minute show emanating from station WKRS in Waukegan represents the longest-running medical interview series on radio.

an acute awareness that medicine must fight with unequalled determination to fend off the tightening grip of socialization. To convey this message with international force and demonstrate how this struggle was being carried out elsewhere, ISMS invited Belgian physician Dr. Joseph J. Farber to address the opening session of the House on Sunday, May 17. A high-ranking officer in the Belgian medical profession and a leader of the now-famed "doctors' strike," Dr. Farber evaluated the action taken by Belgian physicians as a moral necessity. "Restricting government mandates up to and through the time of the strike threatened good medical practice and effective health services in Belgium," Dr. Farber declared.

Contrary to popular opinion, Dr. Farber stated that at no time did Belgian citizens suffer for want of medical care. "During the strike," he said, "the best surgeons, pediatricians, chiefs of departments and other specialists rendered professional services at the hospitals day and night, entirely free of charge to the whole population."

He concluded that this action by a professional group, aided by modern public relations and information techniques, can upset the most elaborate conspiracies against freedom. "However," he warned, "our struggle—as yours—continues."

Only three days later, Dr. Farber's warning was echoed by Senator Roman L. Hruska, Nebraska, guest speaker at the Annual Banquet. "Socialization of medicine is only the first step in the administration's plan to federalize all business and professional enterprise in this country," he declared. "Doctors consequently have become this nation's first line of defense, charged with the responsibility of diverting this headlong plunge into socialism."

scientific programs; "business as usual"

So apparent were the dangers of socialized medicine that they spilled over into the scientific program. At the Public Health section on Tuesday, Dr. Leon J. Taubenhaus, Director of the Public Health Department in Brookline, Mass., warned that physicians must accept the role of leadership in combating community health problems or be relegated to the status of "mere technicians" on government health teams led by laymen.

"We are progressing into the public health era where emphasis is on treatment and diagnosis of the community," Dr. Taubenhaus explained. "However, many competent physicians—trained to cope with individual health problems—become frustrated, confused and lost in the complexities of community health organization."



"DOUBLE FIRST" was scored by Dr. Charles A. Nelson, Pekin, who was first registrant at both ISMS Convention and Annual Clinical Conference of University of Illinois Alumni Association.

For private medical practice to survive in the wake of this trend, Dr. Taubenhaus declared that it is essential for physicians to take the active lead in community health problems. "If we fail," he concluded, "the government will be given the entire job at the demand of the electorate."

While the problems of socialized medicine were thoroughly scrutinized, man's most basic problem—his own health and happiness—was given incisive analysis by Camp Memorial lecturer Dr. Jules Masserman, Professor and Co-chairman of the Department of Psychiatry at Northwestern University.



"MAN'S ETERNAL ILLUSIONS OF HEALTH AND SANITY" were reviewed by Camp Memorial Lecture speaker Dr. Jules Masserman, Professor and Co-chairman of the Department of Psychiatry at Northwestern University Medical School.

Addressing more than 200 physicians in the Sherman House sumptuous Louis XVI Room on Wednesday, Dr. Masserman asserted that the basic threats to man's sanity and emotional well-being are (1) his abhorrence of physical injury; (2) his efforts to guarantee social relationships; and (3) his endeavors to encompass the universe in prescribed philosophies and religions. To treat the patient as whole, Dr. Masserman declared, physicians must not only be practitioners of medicine, but friends and counselors as well. *(Dr. Masserman's paper will appear in a forthcoming issue of IMJ.)*

FINAL REGISTRATION FIGURES

Physicians	2,091
Guests	501
Scientific Exhibitors	90
Technical Exhibitors	292
Woman's Auxiliary	326
GRAND TOTAL	**3,300**



GRATEFUL ACKNOWLEDGMENT is made by Dr. Daniel S. Kushner, left, Chicago Medical School Dean, as he accepts AMA-ERF check from Finance Committee Chairman Dr. B. E. Montgomery on behalf of Illinois' five medical schools. Check, which totaled $132,500, will be divided in following portions: Chicago Medical School $20,683; University of Chicago School of Medicine $19,206; University of Illinois College of Medicine $31,764; Northwestern University Medical School $34,771; and Stritch School of Medicine of Loyola University $26,095.

Dr. Masserman's and Dr. Taubenhaus' talks highlighted four days of 12 scientific sessions featuring more than 50 outstanding speakers and panelists from all over the country. The sessions—often attended by overflow crowds—treated subjects ranging from the development of an artificial heart to the physician's role in restoring and preserving social morality.

Throughout Convention '64, it was "business as usual" for the House of Delegates and Board of Trustees. At the first of three arduous sessions, PR Committee Chairman Dr. Leo P. A.



SOCIALIZED MEDICINE as only part of a plan to federalize all business and professional enterprise in this country was described at Annual Banquet Wednesday night by Senator Roman C. Hruska, Nebraska.

Sweeney announced that baseball great Stan Musial will head up "the greatest Community Health Program in Illinois history." *(Full story in this issue of the Pulse.)* Among the many important policy-making decisions determined by the House was approval for the Public Safety Committee to carry out the first research project ever undertaken by a state medical society to determine the link between drinking and driver deaths. The study—to be carried out by the Public Safety Committee in cooperation with the Illinois Department of Public Health—will utilize blood samples taken from drivers and pedestrians killed in accidents on Illinois highways.

In addition, the House approved a Reference Committee recommendation to establish a medical museum in Springfield. It also approved Dr. Harlan English's report as president, which contained a recommendation to employ educational means to stop the current "population explosion" peril.

Meanwhile, the Board of Trustees got a "sneak preview" of Dr. Sims, ISMS' new identification trademark. Beginning in July, Dr. Sims will spearhead a long-range Society PR program conveying health messages to the public via TV spots, pamphlets, coloring books, newspaper articles and even outdoor billboards. *(A complete Dr. Sims picture story headlines the Pulse in this issue of IMJ.)*

Among personalities in the spotlight during the House' first session was Dr. Daniel S. Kushner, dean of the Chicago Medical School, who accepted the American Medical Association Education and Research Foundation contribution totalling $132,520 on behalf of Illinois' five medical schools. Making the presentation, Dr. B. E. Montgomery of Harrisburg, trustee and Finance Committee chairman, said that ISMS has contributed more than $2 million to AMA-ERF over the past 13 years to lead all other states.

For the second year in a row, all supplementary and reference committee reports were available to the House for their action at the second session—"a tribute," said House Speaker Dr. Walter C. Bornemeier, "to the ingenuity and hard work of the administrative staff."



AWAITING DISPOSITION OF REPORTS Reference Committee Chairmen hover above vice speaker Dr. E. W. Cannady, seated left, and speaker Dr. Walter C. Bornemeier. Standing from left are Drs. Maurice D. Murphin, Miscellaneous Business; Anna Marcus, Administrative Services; Harold C. Lueth, Publications and Scientific Activities; Charles J. Weigel, Public Relations; Joseph R. Mallory, Constitution and Bylaws; Robert R. Hartman, Legislation and Public Affairs; and G. L. Seitzinger, Economics and Insurance.

the elections—in with the new

One of the most important House activities during the Annual Convention is the election of new officers and trustees. This year, the House chose as President Elect Dr. B. E. Montgomery, Harrisburg, former Ninth District Trustee and Chairman of the Finance Committee. In addition to being a member and past chairman of the Medical Advisory Committee to the Illinois Department of Public Aid, Dr. Montgomery is an ISMS delegate to AMA and a member of the AMA Committee on Indigent Care and the AMA Council on Medical Service.

Elected to the posts of first and second vice presidents, respectively, were Drs. Carl F. Steinhoff, Chicago, and L. T. Fruin, Bloomington. Dr. Jacob E. Reisch, Springfield, was re-elected Secretary-Treasurer, while Dr. E. W. Cannady, East St. Louis, was named Speaker of the House, replacing Dr. Walter C. Bornemeier. Dr. Maurice M. Hoeltgen of Chicago succeeds Dr. Cannady as Vice-speaker of the House.



GENESIS AND EXODUS—outgoing ISMS president Dr. Harlan English with Mrs. English, left, and incoming president Dr. E. A. Piszczek with Mrs. Piszczek pose handsomely for their portraits.

On succeeding Dr. Newton DuPuy, Quincy, as Chairman of the Board of Trustees, Dr. William E. Adams, Chicago, commended his predecessor as a capable and dedicated stalwart. "My greatest achievement," Dr. Adams added, "will be to live up to the excellent example Dr. DuPuy has set before me." In addition to his installation as board chairman, Dr. Adams was re-elected as Third District Trustee. Also elected as Third District Trustee was Dr. Ted LeBoy, Chicago, who succeeds Dr. John L. Reichert. Additional new trustees elected by

(Continued on page 609)



NEW OFFICERS AND TRUSTEES. From left, bottom row: Dr. William E. Adams, Chicago, Board Chairman; Dr. B. E. Montgomery, Harrisburg, President Elect; Dr. E. A. Piszczek, President; and Dr. E. W. Cannady, East St. Louis, Speaker of the House. Middle row: Dr. Maurice M. Hoeltgen, Chicago, Vice Speaker of the House; Dr. Paul Younberg, Moline, 4th District Trustee; Dr. L. T. Fruin, Normal, 2nd Vice President; Dr. Jacob E. Reisch, Springfield, Secretary-Treasurer; and Dr. Darrell H. Trumpe, Springfield, 5th District Trustee. Top row: Dr. Charles K. Wells, Mt. Vernon, 9th District Trustee; Dr. Carl F. Steinhoff, Chicago, 1st Vice President; and Dr. Ted LeBoy, Chicago, 3rd District Trustee.



FOR A JOB WELL DONE—Dr. Newton DuPuy, left, Quincy, outgoing Board Chairman, is awarded gold gavel by Secretary-Treasurer Dr. Jacob Reisch in recognition of outstanding performance of his duties over the past two years. Dr. DuPuy's replacement is Dr. William E. Adams, Chicago.



Edward A. Piszczek
President

Socialized Medicine Avoids Means Test, New Prexy Attests

(The following are excerpts from Dr. Edward A. Piszczek's inaugural address, made before the ISMS House of Delegates Thursday, May 21.)

I enter office at a time when the public, as a group, is enjoying the highest standard of health care this country has ever known. I also enter at a time when that high standard of care is jeopardized by the government's growing desire to control medical judgments . . . in spite of the fact that the rationing of such things as liquor, tobacco, T.V. sets, or radios, if socialized, could be accomplished more easily, justly, and equitably than medical care.

Such desire stems more from the popular notion in government circles that a man should spend what he earns for his pleasures . . . rather than his needs. He should buy a T.V. set, a trip to Florida, or a sports car, so this reasoning goes, because this is his cardinal right. But someone else should pay for what he really needs . . . such as his life or his health.

This may be the government or anyone else who can be coerced into paying the price for him. And if no one else will pay for it, the doctor should serve him for nothing. Such thinking may be appropriate for the indulged child whose needs are met by his parents but whose earnings for performing household chores may be spent for personal pleasures. But such thinking is not appropriate for a free man in a free society.

This idea is however, embodied in current legislative proposals to provide medical care for all over 65 regardless of need.

Advocates of such proposals admit that their purpose is not to help the infirm needy aged. Their stated purpose is to spare people "the embarrassment" of a means test . . . that is to establish the principle and precedent that some people are entitled to the unrewarded services of others as a matter of right.

Medical care financed through Social Security would avoid such a means test and this is of profound importance to those who believe that medical services should be made available to all over 65 regardless of need. I personally feel that here lies a significant difference between the Social Security approach to medical financing for the aged and our successful Kerr-Mills program sponsored by the late Senator Kerr and the illustrious Chairman of the House Ways and Means Committee, Rep. Wilbur Mills.

We will continue to work in the support and expansion of our Kerr-Mills program in Illinois and do what we can on the legislative scene to encourage good legislation . . . on the national, as well as state level.

Our effort to achieve these goals and broaden our society's program as a whole requires the cooperation and assistance of that tireless organization we can't do without . . . the Woman's Auxiliary. It also requires the continuing assistance of our administrative staff. Our future successes also rest heavily on the support of other organizations such as the Illinois Association of the Professions which has just been organized . . . and our working closely with them. We must inspire them with clarity of purpose to consolidate our mutual goals in implementing our activities.

The Illinois State Medical Society ranks as one of the largest medical associations in the nation. We may never rank as number one in membership . . . but by working together as a solid unit we can rate as the greatest state medical organization.

I ask for your continued confidence and for your loyal support in conducting the affairs of our society and with it, we shall continue to go forward.

the House were Dr. Paul P. Youngberg, Moline, Fourth District; Dr. Darrell H. Trumpe, Springfield, Fifth District; and Dr. Charles K. Wells, Ninth District, replacing new President Elect Dr. B. E. Montgomery.

As in all previous years, high point of House activity occurred May 21 with the installation of a new president. In an emotion-filled ceremony and surrounded by his wife and four lovely daughters, Dr. Edward A. Piszczek, Chicago, accepted the office of 124th president of the Illinois State Medical Society.

A long-time leader in ISMS affairs, Dr. Piszczek is field director of the Suburban Cook County Tuberculosis Sanitarium District and is Clinical Professor and Chairman of the Department of Preventive Medicine and Public Health at the Stritch School of Medicine of Loyola University. In addition, he was Chairman of the Board of Trustees in 1960-61 and served as Third District Trustee for ten years until his nomination as President Elect last year. He also is Councilor-at-large and holds a number of committee appointments with the Chicago Medical Society.

time out for nostalgia

While most of Convention '64 lent itself to plans and preparations for the future, three events were purposefully set aside to recall and revel in past glories. These events were the Fifty-year Club Luncheon; the Past Presidents' dinner; and the Annual Banquet.

Membership certificates and gold pins emblematic of a half century of medical practice were conferred on 33 physicians at the ISMS Fifty Year Club Luncheon on Tuesday. Among new members of the exclusive, 500-member Club were ISMS Past President Dr. James H. Hutton, Chicago, and two lady physicians, Drs. Ninah Litvin and Vita Marzano, also of Chicago. TV personality Alex Dreier, who addressed the 170 golden age physicians at the luncheon, acclaimed them the most select group of a select profession. "My parting wish," he added, "is that each and every one of you could practice medicine for another 50 years."

Opportunity for ISMS past presidents to exchange wisdoms and recall glories of the past was provided at a special dinner Monday evening, May 18. Dr. Jacob E. Reisch, in charge of festivities, said the party was so successful that it most likely will become an annual event.

On Wednesday evening, May 20, an overflow crowd of trustees, delegates, members, their wives, families and guests crowded the beautiful Grand Ballroom of the Sherman House to honor outgoing president Dr. Harlan English of Danville. During the gala affair, hosted by immediate past president Dr. George F. Lull,

NOSTALGIA ran rampant at past presidents' dinner Tuesday night. Honored gentlemen from left are Drs. Arkell M. Vaughn, Chicago, 1955; Raliegh C. Oldfield, Oak Park, 1959; Irving H. Neece, Decatur, 1948; Everett P. Coleman, Canton, 1945-6; Edwin S. Hamilton, Kankakee, 1962; party host Jacob E. Reisch, Springfield; George F. Lull, Chicago, 1963; Percy E. Hopkins, Chicago, 1949; C. Paul White, Kewanee, 1952; H. Close Hesseltine, Chicago, 1961; James H. Hutton, Chicago, 1940; Rolland L. Green, Peoria, 1937; and Leo P. A. Sweeney, Chicago, 1953.





FIFTY YEAR CLUB GUEST SPEAKER Alex Dreier, and Dr. George F. Lull, right, admire plaque emblematic of half century of medical service. Dr. Lull was host at luncheon fete during which 33 new members were initiated into exclusive ranks of the Club.

Dr. English was acclaimed as an innovator and pioneer whose wisdom and energy helped "to push the Society's program to new heights." Incoming president Dr. Edward A. Piszczek praised Dr. English as a teacher who provided "the working tools of this high office and taught me their use." Dr. Piszczek later added, "I accept the outstanding record of my worthy predecessor as a challenge and pledge to devote energies to implementing and extending the programs he has so ably instituted."

One of the most lasting tributes to Dr. English's dedication and energy took place during his last hours as president on Wednesday afternoon. Not content to rest on his laurels even at this late date, he appeared on the CBS *Mike Wallace Show* to discuss his stand on the need for educational means to control the growing "population explosion" peril. His national TV appearance was largely responsible for an unprecedented total of 24 hours of Convention '64 coverage by radio and television, an event so noteworthy that it was contained in a House resolution which passed without vote. *(See this issue of Pulse for complete story of Convention media coverage.)*

new ISMS departments "show their stuff"

More than 200 public affairs-minded physicians and their wives met and exchanged views with their district representatives at a reception and dinner in the Bal Tabarin Monday evening. The Program—sponsored by the newly formed ISMS Public Affairs Committee—featured Dr. Walter M. Judd, former Minnesota Congressman who keynoted the Republican National Convention in 1960. Dr. Judd's inspiring talk on "Professional People and Public Affairs" reinforced the basic aims of the P. A. Committee—that of stimulating physicians and their wives to become active leaders and participants in the public affairs of their community and country.

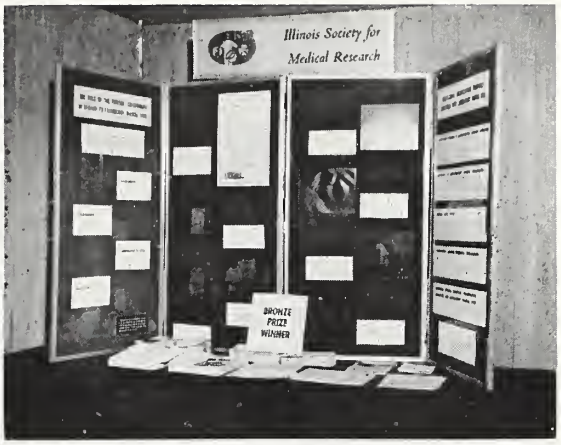
Not even the appearance of entertainer Bob Hope elsewhere in the Sherman House Tuesday night could keep 100 physicians and clergymen from a special medicine-religion panel meeting in the Bal Tabarin. The meeting—which discussed "Spiritual Needs of the Sick"—was cosponsored by the new ISMS Committee on Medicine and Religion and the Catholic Physicians' Guild of Chicago as part of a new campaign to help clergymen and physicians recognize spiritual as well as physical needs in total patient care. Highlight of the meeting was the premiere of ISMS-produced film "Not By Bread Alone," which dramatizes the serious consequences that can occur when physicians and clergymen do not work together. From its Con-

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MEDICINE-RELIGION PANEL in session Tuesday night are from left: The Rev. John Marren, Pastor, Holy Trinity Church, Chicago; Dr. Paul S. Rhoades, Professor of Medicine, Northwestern University Medical School; Rabbi Ephraim H. Prombaum, Chaplain-at-large, Chicago Board of Rabbis; and Moderator Dr. Harold B. Haley, Jr., President, Chicago Chapter, Catholic Physicians' Guild. Panel exchanged views on "Spiritual Needs of the Sick" before more than 100 physician and clergy guests.





AWARD-WINNING EXHIBITS—Among 10 scientific winners are "Prevention of Stroke by Carotid and Vertebral Surgery," a Gold Prize Winner submitted by Veterans' Administration West Side Hospital of Chicago; and "Principles of Laboratory Animal Care," a Bronze Prize Winner submitted by the Illinois Society for Medical Research.

Award Winners—Scientific Exhibitors

Most Original Work

GOLD AWARD: "Pneumotoses Cystoides Intestinalis"

EXHIBITORS: J. M. Coleman, D. F. Cooney, A. Carballo and H. Dizadji

INSTITUTIONS: Dept. of Medicine and Radiology, Mercy Hospital and Mercy Free Dispensary and Vaughn Medical Group, Chicago, Illinois

SILVER AWARD: "Adenomyomatosis of the Gallbladder"

EXHIBITORS: John P. Fotopoulos and Arthur R. Crampton

INSTITUTIONS: Evanston Hospital Association, Evanston, Illinois and Northwestern University Medical School, Chicago, Illinois

BRONZE AWARD: "The Proper Care of Laboratory Animals"

EXHIBITORS: N. R. Brewer and N. J. Kantor

INSTITUTION: Illinois Society for Medical Research, Chicago, Illinois

BRONZE AWARD: "Post-Bulbar Duodenal Ulcer"

EXHIBITORS: William T. Meszaros, Hildegarde Schorsch and Franz Gampl

INSTITUTIONS: Cook County Hospital and Illinois Masonic Hospital, Chicago, Illinois

BRONZE AWARD: "Mechanics of Breathing—Pneumatic and Electrical Analogue"

EXHIBITORS: Christen C. Rattenborg and Duncan A. Holaday

INSTITUTION: The University of Chicago, School of Medicine

Exceptional Educational Value

GOLD AWARD: "Prevention of Stroke by Carotid and Vertebral Surgery"

EXHIBITORS: Hushang Javid, Ormand Julian, William Dye and James Hunter

INSTITUTIONS: Veterans Administration West Side Hospital and Presbyterian-St. Lukes Hospital, Chicago, Illinois

SILVER AWARD: "The Difficult Patient"

EXHIBITORS: Jackson A. Smith and Lester H. Rudy

INSTITUTION: Illinois State Psychiatric Institute, Chicago, Illinois

BRONZE AWARD: "Seven Years' Progress in Psychotropic Medication"

EXHIBITOR: Veronica M. Pennington

INSTITUTION: Psychiatric Service, V. A. Center, Jackson, Mississippi

BRONZE AWARD: "Induced Thrombosis for Intracranial Aneurysms"

EXHIBITORS: Sean Mullen, G. Vailati, C. Reyes and A. Raimondi

INSTITUTION: University of Chicago Hospitals and Clinics, Cook County Hospital, Chicago, Illinois

BRONZE AWARD: "The Normal Placenta"

EXHIBITORS: H. P. Friedman, S. E. Smith and M. W. Huffman

INSTITUTION: Carle Clinic, Urbana, Illinois



INNOVATION—"Complete services" of ISMS were not only on display at Technical Booth Nos. 10 and 11, they were available merely by filling out convenient order form and dropping it in box next to exhibit. Materials available—from all five ISMS Divisions—ranged from pamphlets to radio tapes.

vention '64 premiere the film will be distributed to county societies to stimulate formation of medicine-religion committees at the local level.

The business side of medical practice was considered in detail at a special business management meeting Thursday morning. Sponsored by the newly-formed ISMS Division of Economics and Insurance, the meeting covered such meaty and potentially-profitable subjects as *What Accounts Receivable Means To You; The Importance of LifeEstate Planning;* and *Avenues Open Through Tax Qualified Investment Programs.* More than 50 physicians and their wives attended the meeting, which closed with a question-and-answer session between audience and guest speakers.

Those able to get out of bed by 7:00 a.m. Thursday were treated to an intensive training session in public speaking at a special Speech Training Clinic sponsored by Smith, Kline & French Laboratories of Philadelphia. Recognizing the need to help physicians communicate to the public, SKF instituted their speech training program four years ago under the inimitable directorship of Robert Haakinson.

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Borrowing from Executive Administrator Robert Richard's address to the House, the greatest moments of Convention '64 will not be felt until next year, when its challenges have been met and its policies fulfilled.

Summary of Abstracts of Actions—1964 House of Delegates

Following is a summary of the actions taken by the House of Delegates during the 124th Annual Convention of the Society. This is to serve as your official notification and minutes. If there are any questions do not hesitate to contact the Executive Administrator. A verbatim transcript of the actions will be available in the headquarters office if you should desire to read the details.

Perhaps the single most interesting action to the membership was taken on the last day of the meeting when the House of Delegates adopted a supplementary report of the reference committee on Legislation and Public Affairs. A substitute resolution was approved which authorized, *in addition to the regular annual dues, a bill to each member for the additional sum of $20 which shall be a voluntary contribution. One-quarter of his contribution shall be allocated to the Medical Benevolence Fund. The balance shall be used for the support of the Society's Public Affairs Program, and for the financial support of political education and action through appropriate agencies.*

In order that those delegates who were not available at the last session of the House may have the full details a complete copy of the Supplementary Report of the Reference Committee on Legislation and Public Affairs is included. In addition to approving the report, the House took the following actions:

1. The matter of timing on the billing to the membership was referred to the Board of Trustees for consultation with legal counsel.
2. The possibility of having this voluntary contribution or any portion thereof ruled to be tax deductible was referred to the Board of Trustees for consultation with legal counsel.

Dues For 1965

Upon recommendation by the Board of Trustees, the dues for 1965 will remain the same as in 1964, i.e., $58 for the General Fund, $20 for AMA-ERF, and $2 for Medical Benevolence—a total of $80.

Request From the Speaker of the House

The newly elected Speaker and Vice-Speaker of the House of Delegates will welcome any suggestions regarding the operation of the House for the 1965 session.

Please forward such suggestions to the Speaker,
Edward W. Cannady, M.D.
4601 State Street
East St. Louis, Illinois
as soon as convenient.

Jacob E. Reisch, M.D.
Secretary-Treasurer

SUPPLEMENTARY REPORT OF THE REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC AFFAIRS

Your Reference Committee held further public hearings on Resolutions 64-8, 64-21, and 64-24. In addition to comments from many interested Delegates, we were privileged to hear remarks and opinions of many of the Trustees and Officers of the Society.

It was the consensus that pressing needs exist in the areas of Medical Benevolence, Public Affairs, and political education and action. It is evident that if these needs are to be met, there must be increased effort on the part of each member of the Illinois State Medical Society.

In the area of Medical Benevolence, there are three objectives: first, to ease the constantly recurring deficit in the Benevolence Fund; second, to increase alowances in certain pressing and worthy cases; and third, to increase the invested emergency reserves of the Benevolence Fund—or, in simpler phraseology, to take care of our own in a manner consistent with the high principles heretofore subscribed to by this House.

With respect to Public Affairs, political education and political action, your Reference Committee was impressed with the urgency of the need for greater efforts to advance the cause of education, to the end that the virtues which have won our great nation the envy and respect of the world may be more brilliantly illuminated and emphasized. We again urge that each one of the Delegates to this body carry the message of need for action to his local community. We urge that you accept the findings of your Reference Committee and that you assume the personal responsibility of delineating our actions and mutual concern at the next meeting of your hospital staff or your county medical society.

Resolutions 64-8 and 64-24 dealt only with Medical Benevolence. Resolution 64-21 was concerned, in addition, with the field of Public Affairs, political education and political action.

Your Reference Committee has attempted to combine the essence of these Resolutions, and offers the following Substitute Resolution for your approval:

WHEREAS it is incumbent upon the Illinois State Medical Society to provide leadership in all

1964-1965 ISMS Officers and Board

Officers

President, Edward A. Piszczek, 6410 N. Leona Ave., Chicago
President-Elect, Burtis E. Montgomery, Harrisburg
1st Vice President, Carl F. Steinhoff, 720 N. Michigan Ave., Chicago
2nd Vice President, Leon T. Fruin, 300 North Street, Normal
Secretary-Treasurer, Jacob E. Reisch, 1129 S. 2nd St., Springfield

House of Delegates

Speaker, Edward W. Cannady, 4601 State St., East St. Louis
Vice Speaker, Maurice M. Hoeltgen, 1836 West 87th St., Chicago

Board of Trustees

1st District	Carl E. Clark, Sycamore	1965
2nd District	Ralph N. Redmond, 101 East Miller Rd., Sterling	1965
3rd District	Caesar Portes, 25 E. Washington St., Chicago	1965
	Frank J. Jirka, 1507 Keystone Ave., River Forest	1965
	Philip Thomsen, 13828 Lincoln Ave., Dolton	1966
	J. Ernest Breed, 55 E. Washington, Chicago	1966
	William E. Adams, 950 E. 59th St., Chicago	1967
	Ted LeBoy, 330 Gale Ave., River Forest	1967
4th District	Paul P. Youngberg, 1520 Seventh Ave., Moline	1967
5th District	Darrell H. Trumpe, St. John's Sanatorium, Springfield	1967
6th District	Newton DuPuy, 1101 Maine St., Quincy	1966
7th District	Arthur F. Goodyear, 142 E. Prairie Ave., Decatur	1967
8th District	Wm. H. Schowengerdt, 301 E. University Ave., Champaign	1967
9th District	Charles K. Wells, 117 N. 10th St., Mt. Vernon	1966
10th District	Willard C. Scrivner, 4601 State St., E. St. Louis	1966
11th District	Bernard Klein, 4 E. Clinton St., Joliet	1965

Trustee-At-Large, Harlan English, 909 N. Logan Ave., Danville

Chairman of the Board: William E. Adams, 950 E. 59th St., Chicago

AMA Delegates (elected to take office (or continue to serve) January 1, 1965) Maurice M. Hoeltgen, Leo P. A. Sweeney, H. Close Hesseltine, William K. Ford and B. E Montgomery

AMA Alternates (elected to take office (or continue to serve) January 1, 1965) Theodore R. Van Dellen, Allison Burdick, Sr., Arkell M. Vaughn, Paul A. Dailey, and Fred C. Endres

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matters regarding health and medical care in the State of Illinois; and

WHEREAS it is increasingly apparent that public affairs and political education and action are becoming most important parts of Medicine, both now and for the future; and

WHEREAS a deficit occurs annually in the Benevolence Fund which has had to be financed out of general funds; and

WHEREAS this Fund should be placed on a sound financial basis;

NOW THEREFORE BE IT RESOLVED that the House of Delegates authorize, in addition to the regular annual dues as established by this House, the billing to each Member of the additional sum of $20.00, which shall be a voluntary contribution. One-quarter of this contribution shall be allocated to the Medical Benevolence Fund. The balance shall be used for the support of the Society's Public Affairs Program, and for the financial support of political education and action through appropriate agencies.

Mr. Chairman, I earnestly move the adoption of this Resolution and this report.

Respectfully submitted,
Robert R. Hartman, *Chairman*
L. T. Fruin
Casper Epsteen
William Hutchison
Joseph R. De Caro

ADMINISTRATIVE ACTIVITIES

Report of the President

Dr. English effectively expressed the major issues before the medical profession—medical education, public health, county medical centers, medical insurance, the costs of hospital care, public aid, the population explosion, and the growing interest in mental health.

The Illinois Medical Journal Committee will explore joining with surrounding states, but providing a special "Illinois News Section" to maintain

individual interest. Pooled would be overhead costs, advertising income with raised rates based upon circulation, and the opportunity to be most selective in the publication of scientific material.

Referred to the Board for study was a recommendation that the annual convention be held near the dates of the Chicago Medical Society Clinical Conference. When AMA sessions are in Chicago, the House of Delegates of the ISMS might schedule its meeting at approximately the same time.

President-Elect

Dr. Piszczek recommended all members of the ISMS join local, state and national Chambers of Commerce. These organizations are powerful and their interests parallel those of the medical profession. Anything medicine can do to support them—they do in support of themselves.

The Illinois Association of Professions may act as a forward step in efforts against the total centralization of power in the hands of the federal government.

The Budget

Members of the reference committee familiarized themselves with the various items in the budget and initiated exhaustive discussions in order to understand the intricacies involved in the financial affairs of such a large and diversified organization as ISMS.

The committee reported the following conclusions:

1. Most criticism of the administration of the society finances stems from a lack of understanding of the financial structures. Complete explanations and understanding result in justification for expenditures.

2. Justification of the deficit budget for 1964 was presented by outlining the attempt to fully estimate, or perhaps over-estimate, the requirements to be met in the fiscal year.

3. The new Public Affairs Committee and its important activities accounts for much of the financial expenditures. The reference committee specifically called the attention of the House to the vital importance of avoiding "the most unpleasant experiences of our medical colleagues in a certain Canadian province to the north, and in countries in other parts of the world" and stated "WE MUST MAKE EVERY EFFORT AT THIS MOMENT TO EDUCATE OUR OWN PROFESSION AS WELL AS OUR PATIENTS—THE PUBLIC."

4. Under the present administration there has been only a 2.4 per cent increase in salaries to the employees while there has been a 4.4 per cent increase in fringe benefits for them.

5. The Executive Administrator's report brought out that salaries constituted slightly under 40 per cent of the total budget—well within the prescribed procedure for service organizations.

6. The expenses in the area of medical economics constitute virtually the entire time of one administrative assistant, namely the Kerr-Mills Program activity, Relative Value Study, Drug Formulary and the Manual for County Committees on the Aging.

Other items considered were the various reports of the members of the Board;

The report of the Chairman of the Board, Dr. DuPuy; the work of the Department of Public Health and the Department of Mental Health. THE COMMITTEE COMMENDED THE CHAIRMAN OF THE BOARD FOR HIS COMPLETE REPORT. HIS REPORT IS RECOMMENDED READING BY ALL MEMBERS OF THE PROFESSION.

Two Illinois physicians are officers of the American Medical Association—Dr. Percy Hopkins, Chairman of the Board of Trustees, and Dr. Walter C. Bornemeier, Vice-Speaker of the House of Delegates.

The committee asked that the actions of the Board of Trustees continue to be abstracted and mailed to all members of the House during the interim between meetings of the policy making body of this society. The House expressed its appreciation for this service during the past year.

CONSTITUTION AND BYLAWS

The House made necessary changes to bring portions of the Bylaws "dealing with citizenship as a prerequisite for membership" into agreement in the various chapters. This action corrected oversights at the 1963 sessions.

Other actions restored the powers of the Committee on Prepayment Plans and Organizations omitted in error when the 1963 issue of the Bylaws were published. Other minor corrections in the "Agenda" were corrected.

Clarification of the membership status of a physician living "on or near a county line" was accomplished by two simple changes. The first made it doubly clear that a physician may BELONG TO ONLY ONE COUNTY MEDICAL SOCIETY. If he joins a society other than that in the county where he resides, WRITTEN PERMISSION must be given by the officers of that society to the medical society where the physician desires to affiliate.

The House approved having the chairman of the Committee on Constitution and Bylaws serve in an advisory capacity to the Reference Committee on Changes in the Constitution and Bylaws. It extended to him the responsibility of attending all the meetings, including the executive session in which the report of the reference committee is prepared.

The request (in the form of a resolution) that resolutions submitted too late for publication and distribution to members of the House prior to the meeting be penalized was NOT APPROVED. The reference committee stated:

"It is the opinion of your committee that representatives of the county medical societies will exercise proper judgment and report back to their component societies on all actions taken. All resolutions, and annual reports, are studied by members of the House and are discussed in reference committees. Important items coming before the House are usually well known beforehand, and have been discussed at the county level."

A change in *CHAPTER VII—District Committees* makes is possible for any district to develop a new district committee to serve any area need. The original request was received to permit a Laboratory Evaluation Committee to be established at the District level. However, the reference committee felt that the Districts should be allowed to provide for any existing need as they arise, and that permission should not be restricted to the field of Laboratory Evaluation.

Other actions included granting the Board power to request reports from any committee if the need exists. Approval was given for listing the various "standing (or Constitutional) committees in two categories—those elected by the House—and those appointed by the Board of Trustees.

The House suggested an ad hoc committee be appointed by the Board of Trustees to study the manner in which delegates may be better informed of the discussions before reference committees. All delegates from each Trustee District might meet at breakfast, assign definite reference committee attendance to certain delegates, and ask that a complete report be made at breakfast the next morning on discussions, and pertinent information at the various meetings. This procedure might well develop a closer rapport within the various Districts, and a much better informed delegation from the area. This suggestion is based upon the manner in which the AMA delegation from Illinois functions at the national level.

The House amended the Bylaws so that any physician "in good standing for 35 years and 70 years of age" may APPLY for *Emeritus Membership* at the county society level, and be given that honor. In the past the 35 years membership had to be "continuous." This liberalizes the qualifications and makes it very important that all physicians ELIGIBLE for this honor, consider carefully whether or not they care to cease contributing financially to their society—especially if they are still active in the practice of medicine.

LEGISLATION AND PUBLIC AFFAIRS

A Medical Museum for Springfield. The reference committee recommended to the House of Delegates that it approve plans for establishing a medical museum, and that the ISMS commit itself to raising $85,000 as its pro rata share in restoring the old Capitol Building in Springfield—as well as providing sufficient money to prepare and maintain permanent exhibits in the museum.

Medical Benevolence is being provided some 40 individuals through the activities of this committee. Income from the $140,000 in reserves, $2.00 per capita, plus contributions from the Auxiliary does *not* provide sufficient income annually to meet the obligations. A deficit in the neighborhood of about $6 to $8,000 is met through general funds of the Society.

See Supplementary Report of the Reference Committee on Legislation and Public Affairs.

The Liaison Committee to the Department of Registration and Education was commended for its activity, and requested to continue "its vigilance in helping to maintain high standards of medical practice, and to minimize the risk of the citizenry of Illinois being treated by improperly trained and unlicensed practitioners."

The Committee on Impartial Medical Testimony was asked to continue to provide the courts with "expert testimony" when and if requested to do so. The committee was asked to extend its activities, and increase its efforts to assist the judiciary whenever and however requested.

The Laboratory Evaluation Committee called the attention of the House to the peril which exists if the government should move into the area of supervision and discipline. This field should be covered by the profession. Prompt attention to raising of standards and critical evaluation of laboratories should be the responsibility of the physicians.

Constant personal contact with all legislators was the theme of the report submitted by the Legislative Committee. The reference committee commented: "This is the individual responsibility of each physician to know and to make every effort to keep in touch with his representatives in Springfield and in Washington. The profession should never hesitate to provide consultation in the areas where the profession feels that its interests and the health of the people are involved."

The newly appointed COMMITTEE ON PUBLIC AFFAIRS has been entrusted with the education of the profession in the "areas of public concern." This Committee will develop educational programs in political astuteness, assist the members of the profession in conducting those responsibilities which are part and parcel of each American's responsibility as a citizen. This Committee deserves the financial and personal support of each member of the House.

See Supplementary Report of the Reference Committee on Legislation and Public Affairs.

The House approved a resolution asking that "the Illinois Delegation to the AMA be urged to continue its opposition to all proposals which might place medicine and medical education under obligation to the United States government. This applies espe-

cially to "bricks and mortar" type legislation as well as any other "federal handouts."

The resolution requesting the House support the position of the AMA in advocating HR 8426 and HR 9238 and SB 2560. These bills provide that a refusal of non-profit blood banks and physicians to obtain blood and blood plasma from other blood banks should not be deemed acts in restraint of trade under the laws of the United States.

PUBLICATIONS AND SCIENTIFIC ACTIVITIES

The Committee on Cancer Control was charged with the responsibility of "urging member physicians to advise their patients of the inherent dangers in the use of tobacco and to conduct an aggressive program designed to educate the public of these dangers."

The Board of Trustees was asked to support the third conference on Physicians and Schools in Springfield on December 3, 1964, and was charged with the responsibility of seeing that four physicians be designated from each Trustee District to attend this meeting.

The House asked that Mental Health Form #22 be completed to read that the certification for the discharge of a patient from a psychiatric institution should be permitted only by "a physician licensed to practice medicine in all of its branches," which would limit such examinations to qualified psychiatrists and not permit clinical psychologists to certify these patients. The matter was referred to the Legislative Committee.

The House approved the report recommending that correspondence schools of nursing be condemned, and that ISMS apprise its members NOT to employ or to use graduates from correspondence schools of nursing as they are inadequately trained and insufficiently qualified for nursing care. Liaison between the Committee on Nursing and the various nursing organizations might well be maintained by the use of a consultant to the committee if and when the need arises.

The study of the Joint Perinatal Mortality Committee was approved, and the House asked that the Board give due consideration to sufficient funding to permit this committee to achieve further reduction of perinatal mortality in Illinois.

The name of the Postgraduate Medical Education and Scientific Service Committee has been changed to: THE COMMITTEE ON CONTINUING EDUCATION.

The Committee to Study the Annual Convention (together with the Committee on Scientific Assembly) was charged with the responsibility of continuing its investigation of all possible means to improve the meetings of the ISMS. The reference committee recommended that:

1. Scientific meetings be limited to 3 days, Monday, Tuesday and Wednesday.
2. ONE day to be set aside for specialty groups.
3. TWO days to be allocated to programs of general interest.
4. Lectures to be limited to a maximum of 30 minutes, except in unusual circumstances, and
5. The convention to be a subject for continuing careful study and constructive change.

The Society was instructed to oppose the proposed budget cut of the Tuberculosis Control activity in Illinois during the present biennium. ISMS is to offer its support to the Department of Public Health to maintain present mobile x-ray service for the residents of this state.

The Committee on Medical Education was instructed to apprise the Council on Medical Education of the AMA of the desirability and value of a "twelve month rotating internship," and since this is a national problem, it was recommended that the AMA seek such means as possible to remedy the diminishing emphasis on the rotating service.

The attention of the House was called to the development of the Toxicological Laboratories in Illinois, the vital and important role they can play in assisting the local coroner in the pursuance of his duties whether the case in hand involves a potential crime, disaster or routine problems encountered in his office. The teaching of forensic science in the five medical schools was stressed, and the further enlightenment of all individuals (medical or laymen) holding the office of coroner was stressed.

ECONOMICS AND INSURANCE

The House approved the following recommendations for the Medical Advisory Committee to the Illinois Department of Public Aid after careful consideration of the reports and resolutions:

1. A wide program of education of physicians on all levels to explain the administrative details of the care of public aid recipients.

2. Meetings with officials of the County Departments of Public Aid and the local medical societies should be set up to see what can be done to smooth the administrative machinery of public assistance programs.

3. Urge each county medical society to set up an Advisory Committee and inform the State Society office of all difficulties or problems encountered at the local level.

4. Suggested improvements in procedures should be submitted by county advisory committees to the State Advisory Committee which in turn will present them to the Department of Public Aid at the appropriate time.

District or regional meetings of all members of county medical advisory committees were authorized to assist in the implementation of item 1 listed above.

Fees for services rendered recipients of public aid are to be revaluated—not on a piecemeal basis, but keeping in mind that public aid continues to expand costing the taxpayer more each biennium, and has

become "a way of life with too many people." Realistic fees for service should be provided.

The Board was asked to study the problem of processing disability claims under public aid since in delayed cases, the state loses certain federal funds. The claim passes directly from the local physician to the state level—thus preserving the doctor-patient relationship.

The House approved membership on the Medical Advisory Committee of at least two physicians having in their practice a substantial patient load of public aid patients per annum.

Payment of physicians for the treatment of public aid recipients in hospitals (other than teaching hospitals) should be the same throughout the state of Illinois. The Advisory Committee was requested to continue to negotiate on behalf of the physicians in Cook County.

The monetary food allowance for recipients of public aid was endorsed by action of the House, and the attention of the delegates was called to the study during the past five months by a sub-committee of the Child Health Committee.

All nursing homes within Illinois are to be encouraged by their county medical societies to apply for accreditation by the National Council for Accreditation of Nursing Homes. The Council was established by the AMA together with the American Nursing Home Association.

The Manual on Aging (ready for distribution) will assist all county medical societies in the implementation of local programs for the aging. The success of the entire program is dependent upon active participation at the county society level. The ISMS committee, staff, headquarters office, will continue to cooperate in every way to give active encouragement and assistance to the societies working in this area.

To protect the membership of the society, the House reiterated its stand relative to state-wide fee schedules. By official action the House approved the statement that "no individual committee of the ISMS shall be permitted to approve a fee schedule for the ISMS until it has been submitted and approved by the House of Delegates or the Board of Trustees."

The House approved submitting a resolution to the AMA House of Delegates in San Francisco reiterating the following basic principles in the care of veterans:

1. VA facilities should be used ONLY for the care of service-connected diseases and disabilities;
2. Care of non-service connected conditions should be the responsibility of the individual, or if he is medically indigent, of his community or state;
3. Where care is provided in VA facilities for non-service connected illnesses, it should be provided on the basis that the individual is financially unable to pay for his care outside of VA facilities, thereby indicating medical indigency proved by a means test.

PUBLIC RELATIONS

The PR Committee has successfully parlayed a $3,000 budget into an anticipated $100,000 Community Health Week program.

1. Stan Musial will head our Illinois campaign.
2. The President's Council on Physical Fitness will provide a $5,000 television film and about $1,800 worth of adult physical fitness pamphlets for distribution.
3. The National Dairy Council will produce a $2,500 Community Health Week television spot and at least $83,000 worth of Physical Fitness booklets for all junior and senior high school students in Illinois.
4. The Advertising Council of America will produce and distribute some $3,500 worth of newspaper ad mats.
5. A. H. Wesso Company Foundation is producing $3,700 worth of pamphlets.
6. Illinois Pharmaceutical Association is contributing $1,000 toward the costs of producing posters.
7. Foster-Kleisser Outdoor Advertising will spend an undetermined amount to promote the program.

Further, the House commended the PR Committee on its very complete activities in member relations, radio and television, group liaison, speakers bureau and media relations. County medical societies were urged to take advantage of materials available from the ISMS Committee.

The Disaster Medical Care Committee has conducted a most successful "Medical Self Help Training" course over WTTW and the "tapes" are available for use of downstate television stations—or for sale to industries and organization to promote this important civilian protection throughout the United States. The House approved that the medical profession and the civil defense agencies take a more positive leadership in the shelter program and in the training of the profession in the use of the Civil Defense Emergency Hospitals.

The House requested county medical societies to attempt to develop uniformity in handling ethical relations cases, and asked the state society committee to provide assistance whenever requested.

DISCUSS FEES FIRST was recommended as the best method of reducing complaints and avoiding grievances.

Drivers' licenses and the importance of the physician in several medical aspects were discussed. The committee was asked to continue to study this problem and cooperate with the Legislative Committee if and when laws are developed in this area.

The 12 minute film strip developed by the ISMS

Committee on Religion and Medicine may receive national recognition and may be used by the AMA as a means of encouraging county medical societies to become active in this important program.

MISCELLANEOUS BUSINESS

The Illinois Association of the Professions represents a new administrative body which will work toward expansion to include other paramedical groups. The future of this group will be of interest throughout the state. The ISMS Committee was commended for the work, time and effort expended toward the formation of the new association.

The House asked that the Committee on Quackery cooperate with the various national committees (AMA, etc.) interested in this important means of protecting the citizens of Illinois. There is a "lack of an appropriate definition of 'quackery' ". The Illinois Attorney General, working under the 1961 bill "Consumer Fraud Act" now has wide power to investigate, prosecute and restrain many types of fraud, including "quackery."

The House approved the plans of the Committee on Membership to review and re-evaluate the Society's Bylaws as they pertain to membership. The results of this study are to be turned over to the Committee on Constitution and Bylaws for consideration by the 1965 House of Delegates.

The request that the ISMS furnish malpractice defense for its membership was reviewed by legal counsel. The House was advised that the adoption of this resolution as presented would constitute the practice of law by the ISMS, which would be the "corporate practice of law," and, therefore, illegal.

ACTIONS ON RESOLUTIONS PRESENTED BEFORE THE 1964 HOUSE OF DELEGATES

NO.	ACTION	SUBJECT	REF. COM.
64-1	No action (covered by Item #10 Const. & Bylaws)	Evaluation of Clinical Laboratories Macon County	Const. & Bylaws
64-2	1st Resolve Not Accepted 2nd Resolve Referred to Board 3rd Resolve Accepted	Revision of Convention Procedures H of D Madison County	Const. & Bylaws
64-3	Not accepted	Malpractice Defense for ISMS Members—Jackson County	Misc. Business
64-4	Not accepted	Rotating Internships DuPage County	Pub. & Sci. Serv.
64-5	Accepted as amended	Affiliation with Chambers of Commerce DuPage County	Misc. Business
64-6	Accepted	Mtgs. of County Comm. Ill. Dept. Public Aid—Franklin County	Econ. & Insurance
64-7	Not accepted	Obstetrical Fees under Public Aid Programs—Williamson County	Econ. & Insurance
64-8	See Supplementary Report Substitute Resolution accepted	Increase in Dues for Medical Benevolence—Fulton County	Legis. & P. A.
64-9	Accepted	Medical Soc. Mbrship. & Hospital Staff—CMS	Econ. & Insurance
64-10	Referred to the Board	Public Aid Policy & Disability Exam. Coles—Cumberland	Econ. & Insurance

ACTIONS ON RESOLUTIONS PRESENTED BEFORE THE 1964 HOUSE OF DELEGATES

(Continued from page 619)

64-11	Not accepted	Emeritus Membership Privileges Lake County	Const. & Bylaws
64-12	Accepted as amended	Opposition to "bricks & mortar" grants—Winnebago County	Legis. & P. A.
64-13	No action	Abolition of Scientific Portion of Conv.—Coles-Cumberland	Pub. & Sci. Serv.
64-14	Accepted	Summary of Bd. of Trustees Actions DeKalb County	Adm. Serv.
64-15	Not accepted	Dept. of Forensic Science—U. of Ill. DuPage County	Pub. & Sci. Serv.
64-16	Accepted	Liberalization of Emeritus Mbrship Requirements—CMS	Const. & Bylaws
64-17	Accepted as amended	Physician on Med. Adv. Com. IDPA CMS	Econ. & Insurance
64-18	Accepted	Payment for Med. Care for IDPA Recipients—CMS	Econ. & Insurance
64-19	Accepted as amended	Equal Payment to Physicians Treating Recipients of IDPA	Econ. & Insurance
64-20	Not accepted	Required attendance at County Med. Soc. mtgs.—Southern Cook County Branch—CMS	Const. & Bylaws
64-21	See Supplementary Report Substitute Resolution Accepted	(1) Benevolence Committee (2) Public Affairs Activities	Legis. & P. A.
64-22	Accepted	Blood Banks Activities in Restraint of Trade—Southern Cook County Branch—CMS	Legis. & P. A.
64-23	Not accepted	Food Allowances for IDPA South Side Branch—CMS	Econ. & Insurance
64-24	See Supplementary Report Substitute Report Accepted	Assessment for Benevolence Fund Fulton County	Legis. & P. A.

RESOLUTIONS CONSIDERED AS COMMITTEE OF THE WHOLE

1.	Accepted	Commendations to Hotel, Officers and Staff	Rules & Order of Business
2.	Accepted	Commendations to Media	Public Relations

VOTING POWER OF THE HOUSE OF DELEGATES

FIRST MEETING—May 17, 1964		
Officers and Trustees	21	
Speaker & Vice Speaker	2	
Past Presidents	9	
Delegates to AMA	5	(not listed elsewhere)
Chicago Medical Society	80	
Downstate	87	
Total	199	

SECOND MEETING—May 19, 1964		
Officers and Trustees	20	
Speaker & Vice Speaker	2	
Past Presidents	8	
Delegates to AMA	5	(not listed elsewhere)
Chicago Medical Society	63	
Downstate	81	
Total	179	

THIRD MEETING—May 21, 1964		
Officers and Trustees	20	
Speaker & Vice Speaker	2	
Past Presidents	9	
Delegates to AMA	5	(not listed elsewhere)
Chicago Medical Society	38	
Downstate	72	
Total	146	

OFFICERS—TRUSTEES—SPEAKER & VICE SPEAKER
AMA DELEGATES & PAST PRESIDENTS

		1st	2nd	3rd
President:	Harlan English	X	X	X
President Elect	E. A. Piszczek	X	X	X
1st Vice Pres.	Charles Allison			
2nd Vice Pres.	Ted LeBoy	X	X	X
Secy.-Treas.	Jacob E. Reisch	X	X	X
Speaker:	W. C. Bornemeier	X	X	X
Vice Speaker	E. W. Cannady	X	X	X
Trustees:				
1st District	Carl E. Clark	X	X	X
2nd District	Ralph N. Redmond	X	X	X
3rd District	Wm. E. Adams	X	X	X
	John L. Reichert	X		
	Caesar Portes	X	X	X
	J. Ernest Breed	X	X	X
	Philip Thomsen	X	X	X
	Frank J. Jirka	X	X	X
4th District	Fred C. Endres	X	X	X
5th District	Lee N. Hamm	X	X	X
6th District	Newton DuPuy	X	X	X
7th District	A. F. Goodyear	X	X	X
8th District	W. H. Schowengerdt	X	X	X
9th District	B. E. Montgomery	X	X	X
10th District	W. C. Scrivner	X	X	X
11th District	Bernard Klein	X	X	X
At large	George F. Lull	X	X	X

	1st	2nd	3rd
AMA delegates (not duplicated elsewhere)			
William K. Ford	X	X	X
Frank H. Fowler	X	X	X
M. M. Hoeltgen	X	X	X
H. Kenneth Scatliff	X	X	X
Carl F. Steinhoff	X	X	X
Past Presidents			
Robert S. Berghoff			
Everett P. Coleman	X		
Rolland L. Green			
Edwin S. Hamilton	X	X	X
Harry M. Hedge			
H. Close Hesseltine	X	X	X
Percy E. Hopkins	X	X	X
James H. Hutton	X	X	X
Willis I. Lewis			
Irving H. Neece	X	X	X
Raleigh C. Oldfield	X	X	X
Lester S. Reavley			
Leo P. A. Sweeney	X	X	X
Arkell M. Vaughan	X	X	X
C. Paul White			X

(Continued on page 622)

CHICAGO MEDICAL SOCIETY

	1st	2nd	3rd
Aux Plaines Branch			
John S. Hyde	X	X	X
C. Otis Smith	X	X	X
Herbert Ratner	X	X	
Charles J. Weigel	X	X	X
Arthur E. Joslyn, Sr.	X	X	X
John Boyd		X	
R. Kowal	X		
Joseph C. Sodaro	X	X	
Clair M. Carey		X	
Craig D. Butler	X		
Calumet Branch			
Paul Blackburn	X	X	
Norman C. Meyer	X	X	X
Douglas Park			
Russell Barrett		X	
L. S. Tichy	X	X	X
Otto Koluvek	X		
John D. McCarthy	X		
Raymond Nemecek			
Englewood Branch			
A. J. Sullivan	X	X	
Edward J. Krol	X		
Francis W. Young	X	X	
Frank Kwinn	X		
William Nainis	X		
North Suburban Branch			
Edson Fowler	X	X	
Herbert S. Miller	X	X	
Noel G. Shaw	X	X	X
Jerome T. Paul			
Warren Young	X		
Harold C. Lueth	X	X	X
C. Malcolm Rice, Jr.	X	X	
John L. Savage	X	X	X
George H. Irwin	X		
Wm. H. Harridge			
Irving Park Branch			
George W. Holmes			
F. A. Tworoger	X	X	X
H. L. Wallin	X		X
Eugene M. Narsete	X	X	
Alexander N. Ruggie			
L. F. Mammoser	X	X	X
Arthur T. Haebich	X	X	
T. J. Conley	X	X	X
Jackson Park Branch			
William J. Hand	X	X	
David S. Fox			X
Andrew J. Brislen	X	X	
Wright R. Adams	X	X	X
Frank F. Maple			
Harry L. Hunter			
O. W. Rest	X	X	X
Henrietta Herbolsheimer	X	X	X

	1st	2nd	3rd
North Shore Branch			
Willis Diffenbaugh	X	X	X
Philip R. McGuire	X	X	X
George Turner	X	X	
W. B. Stromberg, Sr.	X	X	X
Karl L. Vehe	X	X	X
Joseph R. DeCaro	X	X	X
W. O. Ackley	X	X	X
Philip M. Bedessem	X	X	
Herschel Browns	X		X
J. B. Murphy	X		
C. A. Norberg		X	
North Side Branch			
Hiram Langston	X	X	
Coye C. Mason	X		
Clifton L. Reeder	X	X	
Michael Boley	X	X	
Roland R. Cross	X	X	X
S. L. Andelman	X	X	X
William Hutchison	X		X
Samuel A. Levinson	X		
Anton Pantone	X	X	
Northwest Branch			
N. J. Kupferberg	X		
M. J. Kutza	X		
M. A. Rydelski	X	X	
A. J. Linowiecki	X	X	X
F. M. Nicholson	X		
Peter N. Furno	X	X	
S. M. Goldberger	X	X	X
South Chicago Branch			
Jack Williams	X		
M. E. Finsky	X	X	X
Simon Saltman	X	X	
Arthur W. Fleming	X	X	X
South Side Branch			
Quentin Young	X		
Robert R. Mustell	X	X	X
Southern Cook County Branch			
Kenneth Smith	X		
Frederick Weiss	X	X	
Stock Yards Branch			
E. J. Lukaszewski	X	X	X
Glenn A. Burckart	X	X	X
West Side Branch			
George Kaiser	X	X	
Anna Marcus	X	X	X
Joseph F. O'Malley	X	X	
George Rezek			
At Large			
T. R. Van Dellen	X	X	X
Morris Fishbein			
Casper Epsteen	X	X	X
Allison L. Burdick, Sr.	X	X	X
Harold A. Sofield	X	X	
Allison L. Burdick, Sr.	X	X	X
Harold A. Sofield	X	X	
Noel Shaw (see No. Suburban)			

COUNTY MEDICAL SOCIETIES

	1st	2nd	3rd
ADAMS—Richard Cooper	X	X	X
ALEXANDER—A. L. Robinson	X	X	X
BOND—Boyd E. McCracken	X	X	X
BOONE—John H. Steinkamp	X	X	X
BUREAU—K. M. Nelson	X	X	X
CARROLL—E. C. Turner			
CASS—B. E. DeSulis			
CHAMPAIGN—H. Ewing Wachter	X		
C. H. Walton	X	X	X
R. E. Schaede		X	
CHRISTIAN—C. D. Brummitt	X	X	
Ralph M. Seaton			X
CLARK—E. P. Johnson		X	
CLAY—Wm. T. Kamp	X	X	
CLINTON—W. L. DuComb			
COLES-CUMBERLAND—Joseph R. Mallory	X	X	X
CRAWFORD—Raymond B. Murphy	X	X	X
DeKALB—T. P. deGraffenried	X	X	X
DeWITT—Herman L. Meltzer	X		X
DOUGLAS—Harry Messmore	X	X	X
DuPAGE—Morgan M. Meyer	X	X	
James P. Campbell	X		
Joseph R. O'Donnell	X	X	X
J. P. Schweitzer	X	X	X
B. L. Rodkinson	X	X	
EDGAR—James H. Acklin	X	X	X
EDWARDS—Charles P. Salisbury			
EFFINGHAM—Wm. S. Vanbergen	X	X	X
FAYETTE—Stanley W. Moore		X	
FORD—Paul W. Sunderland	X	X	X
FRANKLIN—John P. Pope	X	X	X
FULTON—Keith H. Frankhauser	X	X	X
GALLATIN—John E. Doyle			
GREENE—Paul A. Dailey	X	X	X
HANCOCK—Byron I. Mueller	X	X	
HENDERSON—Elmer T. Swann			
HENRY—Paul M. Schmidt	X	X	X
IROQUOIS—R. Kent Swedlund		X	X
JACKSON—J. A. Petrazio	X	X	X
JEFFERSON-HAMILTON—C. K. Wells	X	X	X
JERSEY—W. Clark Doak			
JoDAVIESS—J. Eric Gustafson	X		X
JOHNSON—E. A. Veach			
KANE—John A. Newkirk		X	X
Wayne N. Leimbach	X	X	X
B. F. Shirer	X	X	X
KANKAKEE—John C. Burnett	X		
Donald A. Meier		X	
KENDALL—Max Saxon	X	X	X
KNOX—J. A. Bowman	X	X	X
LAKE—Charles Culmer	X		
Donald Nellins	X	X	X
Earl V. Klaren	X	X	
Michael J. McAndrew			X
LaSALLE—William A. Scanlon	X	X	X
LAWRENCE—Charles G. Stoll			
LEE—Wm. A. McNichols	X	X	X

	1st	2nd	3rd
LIVINGSTON—George T. Crout	X	X	X
LOGAN—Charles R. Bardwell	X	X	X
McDONOUGH—Donald Dexter	X		
McHENRY—M. Mijanovich	X	X	
McLEAN—L. T. Fruin	X	X	X
MACON—C. Elliott Bell	X	X	X
Maurice D. Murfin	X	X	X
MACOUPIN—Joseph J. Grandone	X		
MADISON—Eugene F. Moore	X	X	X
Edward K. DuVivier	X	X	X
MARION—Karl Venters	X	X	
MASON—J. W. McHarry			
MASSAC—George Green	X	X	X
MENARD—H. K. Moulton			
MERCER—M. E. Conway	X		X
MONROE—Joseph Werth		X	X
MONTGOMERY—George A. Telfer	X		
MORGAN—Robert R. Hartman	X	X	X
MOULTRIE—Eugene J. Boros			
OGLE—Russel W. Zack	X	X	X
PEORIA—Wm. O. McQuiston	X	X	X
Norman Powers	X	X	X
F. A. Christensen	X	X	X
PERRY—C. E. Cawvey	X	X	X
PIATT—Edgar Weir	X	X	X
PIKE-CALHOUN—James H. Rutledge	X	X	X
PULASKI—James G. Conger			
RANDOLPH—Robert E. Schettler	X	X	X
RICHLAND—William A. Moore	X	X	X
ROCK ISLAND—J. G. Gustafson	X	X	X
Theodore Grevas	X	X	X
SAINT CLAIR—Harold McCann	X	X	X
V. P. Siegel	X	X	X
SALINE—N. A. Thompson	X	X	
SANGAMON—Darrell H. Trumpe	X	X	X
Chauncey C. Maher, Jr.	X		
A. R. Eveloff	X		X
SCHUYLER—Henry C. Zingher	X		
SHELBY—H. H. Pettry	X		
STEPHENSON—Thomas A. Haymond	X		X
H. R. Osheroff		X	
TAZEWELL—Lawrence J. Rossi	X		
Roger Neumann		X	X
UNION—William H. Whiting			
VERMILION—G. L. Seitzinger	X	X	X
WABASH—Roger Fuller			
WARREN—Kenneth E. Ambrose	X	X	X
WASHINGTON—Walter P. Plassman	X	X	
WAYNE—C. J. Jannings	X	X	X
WHITE—S. B. Abelson			
WHITESIDE—Isaac Vandermyde	X	X	
WILL-GRUNDY—George H. Woodruff	X	X	X
Leonard F. Roblee	X	X	X
WILLIAMSON—John W. Tidwell	X	X	X
WINNEBAGO—Paul A. Van Pernis		X	X
Harold E. Zenisek	X	X	X
Harry E. LaPlante	X	X	X
WOODFORD—Robert Lykkebak	X	X	X

Griseofulvin U/F in Tinea Capitis

Stefan Bielinski, M.D., and Alfred B. Falk, M.D., *Chicago, Illinois*

Since its introduction four years ago, the orally administered fungistatic agent *griseofulvin* has become the drug of choice in the treatment of *Trichophyton, Epidermophyton,* and *Microsporum* infections of the hair, skin, and nails.

Little is known about how griseofulvin is metabolized in man. Blood levels are found to be highest four hours after oral administration, and they decline to zero within 72 hours. During the 48 to 72 hours following oral administration, increasing amounts of griseofulvin begin to appear in the deepest layer of the stratum corneum and also in the keratogenous zone of the hair matrix. Hyphal invasion of the deeper layers of hair and skin is blocked by the fungistatic action of griseofulvin. Thus, the duration of treatment is governed by the rates of keratinization and desquamation in hair and skin.

Griseofulvin is not well absorbed from the small intenstine. For this reason, therapeutic dosages are rather high. The usual dose is one gram daily for adults, and 500 or 750 mg daily for children. To improve absorbability of the griseofulvin particles, a dosage form was prepared in which the surface area was increased by micronization. Kraml and colleagues[1,2] found that serum concentrations of ultrafine griseofulvin were approximately twice those produced by an equal weight of standard griseofulvin.

The implication that ultrafine griseofulvin can be used in lower doses than the standard form is supported by preliminary clinical trials.[3] This paper compares our results with standard griseofulvin, reported previously,[4] to those obtained with the new dosage form.

From the Division of Dermatology of the Children's Memorial Hospital and the Department of Dermatology of the University of Illinois College of Medicine. Dr. Bielinski is Clinical Assistant Professor and Dr. Falk is Clinical Associate Professor at the latter institution. The ultrafine griseofulvin used in this study was provided as Fulvicin U/F TM by the Schering Corporation, Union, New Jersey.

Procedure

The diagnosis of ectothrix tinea capitis was confirmed by Wood's light in four girls and 27 boys, ranging in age from three to 12 years. The children were treated with 250 mg of ultrafine griseofulvin twice daily on Thursdays and Sundays.

Re-examination by Wood's light was made every two weeks. Treatment was continued for two weeks after the first negative examination.

Comparison of Standard and Ultrafine Griseofulvin

Response to Standard Griseofulvin
(Dosage: 500 mg. twice daily, two days each week.)

Number of patients	Duration of infection before treatment	Average time to first negative examination
44	less than 3 months	7 weeks
13	3 to 6 months	5 weeks
7	6 to 22 months	9 weeks

Response to Ultrafine Griseofulvin
(Dosage: 250 mg. twice daily, two days each week.)

Number of patients	Duration of infection before treatment	Average time to first negative examination
16	less than 3 months	7 weeks
9	3 to 6 months	8 weeks
2	6 to 12 months	8 weeks
4	unknown	6 weeks

If the subsequent examination was negative, griseofulvin was discontinued. The child was then seen four weeks later, and discharged.

Results

This infection cleared in from two to 19 weeks. The average duration of the clearing process was about seven weeks. In 30 patients the examinations remained negative after the first negative report. The second presumably negative report was not recorded in one case. There were no untoward effects.

The results of treatment with standard and ultrafine griseofulvin are compared in the table. The clinical results with standard griseofulvin—reported previously in detail—are from a series of eight girls and 56 boys (ranging in age from 16 months to 11 years) with ectothrix tinea capitis. The results with ultrafine griseofulvin are from the current series. The average time required for cure, in both groups, was approximately seven weeks. Thus, one gram of ultrafine griseofulvin given weekly produced the same results as those obtained by administering two grams of the standard form weekly.

Summary

Comparison between a group of 64 children treated for ectothrix tinea capitis with standard griseofulvin, and a group of 31 children treated for the same condition with ultrafine griseofulvin, indicated that ultrafine griseofulvin produced cures of ectothrix tinea capitis at about half the dosage of the standard preparation.

REFERENCES

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2. Kraml, M., Dubuc, J., and Gaudry, R.: Gastrointestinal absorption of griseofulvin: II. Influence of particle size in man. *Antibiotics & Chemother.* 12:239-242, 1962.
3. Robinson, H. M., Jr., and Dunseath, W. R.: Micronized griseofulvin. *J. Invest. Dermat.* 39:65-66, 1962
4. Fox J. M., Bielinski, S., and Falk, A B.: Treatment of ringworm of the scalp with griseofulvin. *J. Indiana M.A.* 54: 1024-1026, 1961.

Used Equipment Can Save Lives

Hospital and medical personnel in foreign countries often are seriously handicapped through lack of equipment and supplies. Much material that has been superseded here by newer designs could save lives if put to use elsewhere. Hospitals and individuals wishing to contribute usable but no longer needed medical and hospital equipment for shipment to India are asked to contact Jose Gonzalez, M.D., director, International Hospital Program, American Hospital Association, One Farragut Square South, Washington 6, D.C. He will arrange with the appropriate agencies for pickup services and overseas shipment. Present needs are for clinical laboratory and occupation therapy equipment, maternal and infant care equipment and furnishings (incubators, resuscitators, anesthesia machines, suction machines, sterilizers, dressing carts, etc.), general furniture items for housing, waiting room areas, medical books, etc.

Solar Urticaria

Allan L. Lorincz, M.D.

Urticarial hypersensitivity to sunlight, or solar urticaria, is a rather rare, yet well recognized and much studied entity. Ward,[1] in 1905, presented the first detailed description of this disorder. More recently, Epstein[2,3] has reviewed the subject rather extensively.

Characteristic Lesions of Solar Urticaria

In solar urticaria, brief exposure of the skin to sunlight is followed in a matter of minutes by the development of pruritic urticarial wheals. These are precisely confined to the sun-exposed areas.

Solar urticaria usually commences in the form of multiple discrete wheals, which then become confluent in the irradiated area as sunlight exposure continues. Generally, this entire whealing process takes place within three to 10 minutes after exposure to sunlight. Diffuse axon reflex erythema accompanies the urticaria and extends into the surrounding non-exposed skin. The quantity of sunlight required to elicit this reaction is only a minute fraction of the amount required to cause sunburn. The whealing reaction persists for from one-half hour to several hours, depending on the intensity of exposure.

In all of its features the whealing reaction is analogous to urticarial hypersensitivity reactions to foods, drugs, and to physical phenomena such as mechanical stimuli, cold, and heat. Histamine is assumed to be the final mediator of the reaction, which can be suppressed with sufficient amounts of antihistaminic agents.

In widespread reactions, gastric secretion may be greatly stimulated by the liberated histamine. This may cause the patient to experience general symptoms of malaise, and even to go into histamine shock. All areas of the skin in affected persons manifest the reaction to sun exposure but chronically exposed areas such as the face and hands may tolerate severalfold greater doses of light before urtication develops.

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Role of Spectral Wavelengths of Sunlight

In the past couple of decades much attention has been paid to determining the spectral wavelengths of sunlight which cause solar urticaria in individual cases. It was early noted that sunlight passing through window glass could still elicit the reaction which is, of course, in sharp contrast to the well-known efficacy with which window glass screens out the sunburn erythema producing wavelengths of sunlight. Since window glass cuts off ultraviolet wavelengths below 3200 Å. the action spectrum of solar urticaria obviously extends to wavelengths above this.

More refined observations by many workers using selective light filters and more recently monochromators as pioneered by Beal[4] in this country, and Burckhardt,[5] Porter[6] and Magnus and co-workers[7] in Europe have shown that at least two major types of solar urticaria can be distinguished on the basis of different action spectra. In one type the sensitivity spectrum is in the ultraviolet range below 3700 Å. while in the other type blue light between 4000 and 5000 Å. causes the reaction. The latter type appears to be more common. The action spectrum of the less than 3700 Å. type of solar urticaria as determined by Beal extends from about 2900 Å. to 3350 Å. with a peak at about 3150 Å. This type of solar urticaria usually begins suddenly at any time in life even in childhood. Little is known about precipitating factors although intense over-exposure to sunlight has preceded the onset in some cases. In a few others, similarly to cold urticaria, onset has followed infections or stings by insects, jelly fish or ray fish.

In general solar urticaria tends to occur more frequently in women, the ratio of females to males being about 3 to 1. The duration of the

disorder is usually measured in terms of years or decades. Those patients who are sensitive only to visible blue light tend to have a poorer prognosis in regard to persistence of the difficulty.

In some cases solar urticaria of a temporary sort may accompany the administration of photosensitizing drugs such as sulfonamides. Such drug-induced solar urticaria may apparently be based on urticarial allergy which develops to a photochemical metabolite of the drug. Direct histamine liberating action not based on any antibody mechanism can also result from photochemical activation of some drugs and so cause solar urticaria. This type of urticarial reaction falls into the general group of light sensitivity reactions which are termed photodynamic or phototoxic. The old liver function test dye, rose bengal, when injected intradermally, can produce local solar urticaria by this mechanism.

Whether the non-drug induced types of solar urticaria are based on photoallergic or phototoxic mechanisms has been much discussed. In the less than 3700 Å. or ultraviolet type of this disorder, passive transfer of the sensitivity with serum by the Prausnitz-Kustner technique usually succeeds in contrast to the blue light sensitive types in which such transfer usually fails. The serum passive transfer factor is heat labile as are skin sensitizing serum antibodies in general. Successful passive transfer has been taken to support the photoallergic nature of the ultraviolet type of solar urticaria. It has generally been assumed that in this type of the disease allergy develops to an unknown photochemical metabolite which arises normally in everyone's skin as a result of irradiation with the specific wavelengths in question. This contention receives further support by the occasional report[2] of successful reverse passive transfer of the reaction. In this reverse technique a skin area of the normal test subject is irradiated with the appropriate light and subsequently the sensitive individual's serum is injected into the irradiated site where it leads to an urticarial response. Furthermore, I have observed in a patient with this ultraviolet type of solar urticaria that stripping away of the cornified layers of the epidermis with repeated applications of cellophane adhesive tape prevents the solar reaction locally even though such stripped areas can still wheal in response to direct applications of histamine.

The mechanism of the blue light type of solar urticaria at least in some cases has been clarified in the past couple of years with the demonstration by Magnus, Jarrett, Prankert and Rimington[8] of the existence of a new distrubance of porphyrin metabolism in such patients. They named this metabolic disturbance erythropoietic protoporphyria. It is not characterized by urinary excretion of abnormal amounts of porphyrins or their precursors, as is the case in the usual porphyrias, but rather by abnormally high accumulations of protoporphyrin in the erythrocytes. This abnormality sometimes can be detected by red fluorescence of erythrocytes and bone marrow normoblasts as observed under ultraviolet microscopy but is best established by measurement of high protoporphyrin and coproporphyrin excretion in the stools and by high levels of these substances in the red blood cells.

Familial, apparently recessively inherited, occurrence of this type of protoporphyria has been reported in a set of siblings[9] although most cases apparently occur sporadically. On occasion solar eczema or polymorphic type light eruptions have been associated with this type of erythropoietic protoporphyria.[10] It appears that a direct photodynamic or phototoxic mechanism rather than allergy lies behind the blue light sensitivity in these cases.

The management of severe solar urticaria presents an urgent and sometimes very difficult problem. The usual invisible sunscreening preparations, such as those based on para-aminobenzoic acid or its esters which protect against sunburn, are ineffective. Only opaque sunscreening preparations containing zinc or titanium oxides offer protection. Chemical sunscreens which might cover the spectral ranges involved either are cosmetically too colored to be acceptable or offer an insufficient degree of screening in the spectral ranges involved to prevent difficulty. Carotene preparations topically have been of some limited value in the blue light sensitive cases.

Although an occasional observer has claimed some benefit from chloroquine therapy in the ultraviolet type of solar urticaria I have not

been able to obtain such improvement with this treatment in the patients I have observed.

Rubin, Beal and Rothman[11] in 1947 reported what in my experience has been an important really practical approach to the management of solar urticaria in addition to the usual suppressive or symptomatic use of antihistamines. Strict avoidance of exposure to bright light is generally not practical.

Under the cover of antihistamines, these workers gradually exposed their sensitive patients to ultraviolet or sunlight until protective sun-tanning and horny layer thickening were achieved. Such tolerance could be reached and maintained by daily exposures that antihistamines could be stopped. Whereas the antihistamines in average doses increased solar tolerance only six fold, their technique achieved a 200 fold increase in solar tolerance. No immunological desensitization was involved because covered areas which were not regularly irradiated in these cases failed to show any increased tolerance, and when regular ultraviolet radiations were discontinued the disorder recurred. The cases reported by these authors were of the ultraviolet sensitive type. It would further seem reasonable to try to speed up the development of this type of tolerance by the use of psoralens concomittently with ultraviolet irradiations. It is likely that this method of management may be less effective in the blue light sensitive cases because of greater ease of penetration of such light through the superficial cornified epidermal layers. Blue light induced solar urticaria incidentally, can be readily elicited on areas with normally very thick horny layers such as palmar skin because of the relatively great blue light penetrability of such layers.

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Acne Remedies

According to a recent report in American Druggist, eighty two per cent of all acne products are sold by drug stores. This figure includes over-the-counter and prescription items. With supermarkets and discount houses making a successful bid to attract this market, druggists have some new ideas on how to stem the tide.

Up until now the druggist has not been in any danger of losing this market. Prescription items constitute 50 per cent of the total sales of these products. The main competitor is not the physician, but the supermarket. Aware of the great potential of this market, supermarkets are making a bid to enter this field.

Teenage population has increased faster than the population as a whole and will continue to do so. Usually sensitive in asking for help about skin problems the teenager is attracted to the self-service department designed especially for his needs. Today's young adult has more money to spend on personal items and does so freely to minimize or hide skin conditions.

By establishing a special section of this type the druggist is planning to combat the supermarket invasion into a field previously considered his domain. He is trying to get the teenager to consider his store as the logical place to purchase these items.

The druggists believe that they will be able to keep the existing market and also increase their sales because of the health nature of these products.

T. R. Van Dellen, M.D.

The View Box

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital

A 41 year old Negro male was admitted to the hospital with symptoms of belching and distension of two weeks' duration. Four days prior to admission his urine became dark and his stools were light in color. He had been hospitalized in Arkansas in 1934 for swelling of the legs and abdomen.

Physical examination revealed a nodular liver, palpable five finger-breadths below the costal margin. There was evidence of ascites, with fluid wave and shifting dullness on percussion.

Blood chemistry was as follows: Cephalin flocculation 4+, thymol turbidity 13.4, alkaline phosphatase 9.6, icterus index 211, cholesterol 78 with 17 per cent esters.

What is your diagnosis?

1. Echinococcus disease of liver and spleen
2. Calcified miliary tuberculosis of liver and spleen
3. Calcification in old subphrenic abscesses
4. Hepatoma resulting from Thoratrast
5. Sickle cell disease

(Continued on page 633)

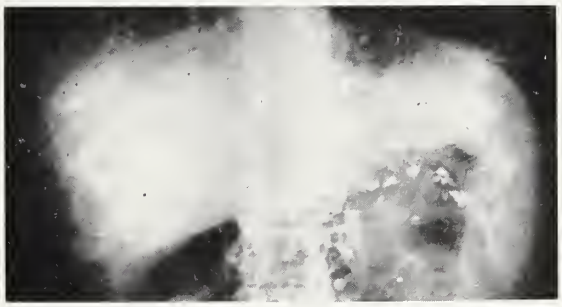


Figure 1

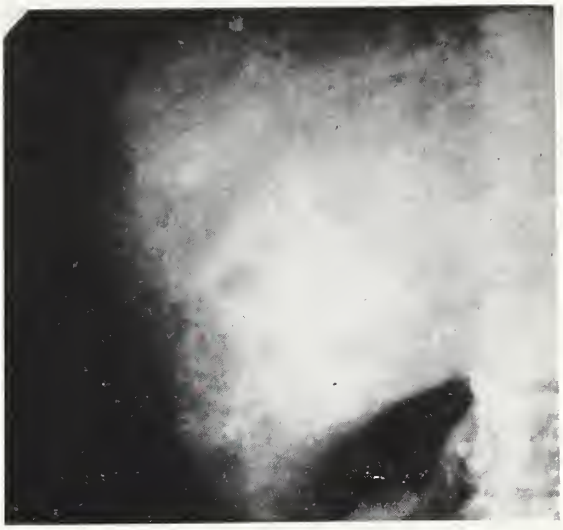


Figure 2

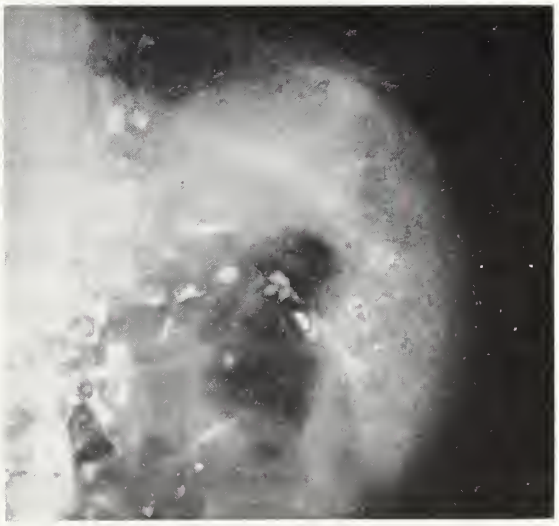


Figure 3

Drug Sensitivity in Obesity: Clinical Experiences with the Seven-Question Test

Frank L. Bigsby, M.D. and Cayetano Muniz, M.D., *Chicago, Illinois*

An understanding of obesity depends on a knowledge of the various types of obese condition seen clinically. Any discussion of prognosis, incidence, altered physiology, motivation, psychotherapy, and chemotherapy is meaningless if there is no definite obese classification. A discussion of chemotherapy in obesity will serve to illustrate these views.

Prescribing anorectic agents is perhaps one of the most mis-used forms of therapy in the practice of medicine. Frequently quoted indications for anorectic therapy include "elevation of mood while dieting," "increasing energy expenditure in the sedentary," and the "control of hyperphagia in the weak willed."

One problem that confronts the physician is estimating the degree of tolerance the patient will display. This often is a matter of guesswork, and the prescriptions are written without regard to the patient's eating pattern or to any other objective indications. Surprise may follow the discovery that the obviously tense patient demands—and tolerates—the most potent drug, while the seemingly calm patient reacts violently to even a bland preparation.

To facilitate estimation of tolerance to drug therapy, the following questions have been found helpful. When correlated with a detailed obesity history, the seven questions provide insight into other interesting aspects of overweight. Classification and information regarding drug allergy are but two examples of benefits to be derived.

Seven-Question Test

1. Did you formerly tolerate appetite depressants poorly?
2. Are you a rapid eater? Do you gulp your food?
3. Do you suffer from insomnia?
4. Do you experience a late-afternoon letdown? (Fleeting hypoglycemic episode)
5. Can you spend the day without eating, and do you then subsist on coffee and cigarettes?
6. Do you eat without hunger and is food, for the most part, tasteless?
7. Once you start the intake of sweets, do you have difficulty stopping?

   Note: Generally speaking, the more affirmative answers obtained, the greater should be the caution in prescribing anorectic agents.

Clinical experience in applying the above questions alerts the physician to the variations of interpretation that may be employed. Furthermore, evaluating tension states and the eating pattern may be enhanced. A common therapeutic error is the empirical use of slow-release anorectic drugs in the early hours of the day, notwithstanding the fact that the patient does not eat breakfast or lunch. It is small wonder that the physician frequently obtains a history of intolerance to these preparations.

To demonstrate various conclusions to be derived from the seven-question test, it is best to consider and study some common types of obese patients seen in clinical practice.

The Tension Night Eater

This type obese patient may open the first interview by stating, "If all you can do for me is prescribe an appetite drug, let's not waste each other's time. I have tried them all and can't take even the mildest forms."

At initial interview, the physician observes a tense, alert, anxious patient who displays an attitude toward ventilation of the various aspects of disappointing experiences in past reducing regimens. The seven-question test will reveal insomnia and a lack of appetite for breakfast and luneh. There is, instead, a preference for coffee alone or combined with a pastry. Food is tasteless, and the patient eats without appetite or hunger. Onee food ingestion begins in the late afternoon or at dinner the eating process eontinues unabated until bedtime.

There is a strong predilection for sweets and starches. A fleeting mid-afternoon episode of hypoglycemia is a frequent finding. This is characterized by malaise, nausea, irritability, sweating, and a vague desire for something to eat or to drink. The patient often displays other symptoms which can be attributed to conditions such as tension, spastic colitis, high abdominal distention, palpitation, and aeidosis.

Examination shows overweight to be moderate—perhaps by about 15 or 20 pounds. The pulse-pressure may be low, and a blood pressure reading of 105/95 is a common one. The pulse rate is often rapid. Excess adipose deposits may follow no definite pattern. Nonetheless, many patients display gain about the midriff.

This description is typical of the tension night eating syndrome. Such a patient requires astute management. This does not include medication to curb the appetite. Sympathicomimetie agents can have but one result—they further stimulate the nervous system that is already on the verge of collapse. The tension night eater often answers all seven questions of the test in the affirmative. This should alert the physician to preseribe sedation rather than sympathicomimetie drugs in his early prescriptions.

Nutritional Obesity

The nutritional obese individual is considered next for a definite reason—the seven-question test may be pathognomonic in differential diagnosis between this patient and the Tension Night Eater.

This patient presents the following typieal eating pattern: A breakfast of coffee—often many cups. Fruit juice may sometimes be added. Lunch might include a cup of soup, cottage cheese and fruit, or perhaps one-half sandwich —and still more coffee. Perhaps lunch is missed entirely or it consists of eoffee only. Dinner may be the first meal of consequenee, but rarely is the patient able to resist second portions or eating throughout the evening. Daytime snacks are not common.

Examination discloses a rather calm patient whose overweight is seldom in the higher categories. No particular pattern of exeess adipose tissue deposits are evident. The remainder of the physical examination may be non-informing.

The Seven-Question Test in Nutritional Obesity

1. Did you formerly tolerate appetite depressants poorly? Answer—No.
2. Do you gulp food? Answer—No.
3. Do you suffer from insomnia? Answer—No
4. Do you experience a late afternoon letdown? Answer—No. (If the answer is yes, the episode is minor and difficult to establish.)
5. Can you go all day without eating and drink coffee or tea? Answer—Yes.
6. Do you eat without hunger and is food tasteless? Answer—No.
7. Once you start the intake of sweets, do you have difficulty stopping? Answer—No.

With the exception of question 5, the answers are all negative, and they are contrary to those supplied by the tension night eater.

The diagnostie feature here rests in clarification of the answer to the fifth question. This patient is obviously a rather stable type. Why should he then have an eating pattern that seems to closely parallel that of the tension night eater? The answer rests in the fact that the nutritional obese patient develops this eating pattern as a result of years of poorly supervised "dieting" and calorie counting. With him, all sense of nutritional balance has vanished. He has no understanding of what comprises an intelligent reducing regimen. Obesity stems from the absolute inability of all but a few of such patients to consume a reasonable amount of calories from dinner until retiring (the hours during which energy expenditure decreases).

In the night eater, the picture is one of tension. In the nutritional obese person it is igno-

rance of what constitutes balanced nutrition. Thus is seen a second application of the seven-question test. Should the physician depend on the eating pattern alone to establish diagnosis, confusion may exist and therapeutic management be hampered.

Natural Make-up Obesity

The natural make-up obese patients present the common distinguishing feature of always being taller and heavier than persons about them. Women of Polish or Russian descent exemplify this type. Such a woman will particularly recall that in elementary school her classmates were smaller. As an adult, her features are broad, the skeletal system heavy, the weight often in the 160-180 pound range, the height greater than average.

The eating pattern may be quite regular with morning, noon, and evening meals consisting of reasonably well balanced portions—the expected penchant for bread and potatoes is extant. Excessive snacking is not typical.

Physical examination reveals the heavy features described above. The weight may be 170 pounds. From the use of skinfold calipers, it may be determined that there is but 15 pounds of excess adipose tissue present. The physician will note that the single manifestation of tension is frustration about oversize. The patient, and perhaps the doctor, mistakenly compare the weight against the frequently mis-used average-weight chart.

The Seven-Question Test in Natural Make-up Obesity

1. She eats slowly.
2. She tolerates appetite-curbing drugs well.
3. She sleeps well.
4. She experiences no mid-afternoon letdown.
5. She eats fairly well balanced meals regularly.
6. She enjoys taste of foods.
7. Her liking for sweets are not excessive.

It is apparent that the answers given to the seven-question test denote the projected tolerance to sympathicomimetic drugs to be excellent.

To illustrate another use of the seven-question test, assume that the patient described above reacts violently to the starting dosage of an amphetamine preparation. The initial prescription excites insomnia, extreme nervousness, irritability, emotional instability, palpitation, precordial pain, dryness of the mouth, petechiae or skin rash. The logical conclusion to be drawn, in view of the results of the test, is that an actual drug sensitivity is extant, that amphetamine drugs should be totally excluded in the reducing regimen.

The Obese Compulsive Eater

Typically, the obese compulsive eater is the patient who describes herself as a 'garbage pail' for her children. She eats anything at hand—sweets, starches, fats, proteins—simply because of its availability. She often eats so much, and so rapidly, that the food she has eaten could not possibly be itemized one hour later. Seldom does this disorganized patient sit down for a complete meal, and any attempts to ascertain what she has consumed at the three meals are fruitless.

The seven-question test may be answered in the same disorganized manner. The gulping of food is always evident. Sweets and starches may predominate (low cost and availability are factors). Insomnia may prevail, yet this may stem from disorganized sleep habits rather than from tension. No definite afternoon syndrome suggesting an episode of hypoglycemia can be determined. Nonetheless, chronic malaise is common. Excessive coffee intake, as well as other liquids, may be a part of the compulsive pattern and may further confuse matters. Food is gulped too rapidly to be tasted. Questions relating to toleration of drugs to control hyperphagia in past reducing regimens may surprisingly reveal a history of tolerating the preparations in prodigious amounts.

The weight range is quite variable, most often the patient is from 20 to 30 pounds overweight—there is no definite trend as to weight distribution. It is difficult to gain this patient's undivided attention. Insight and rapport are notably poor. In this obese type, the physician must cope with one of the most difficult of all patients. He must have some knowledge of surface psychotherapy as well as an understanding

of his own limitations in this field. Thus qualified psychiatric care should be advised when indicated.

When correlating the conflicting features of the clinical history, physical findings, and the seven-question test, the existence of a severe tension state is obvious. Not so obvious is the toleration of heavy dosages of amphetamine drugs often exhibited. These patients have undoubtedly demanded, and received, extreme amounts of anorectic drugs in past regimens.

Only two logical conclusions to be drawn: (1) That, through exposure to drugs, the patient is habituated, and (2) that the tensions are primarily of emotional (not physiological) origin, and that the sympathicomimetic drugs are thus better tolerated.

The View Box

—diagnosis and discussion *(Continued from page 629)*

Diagnosis: Hepatoma Resulting

From Thoratrast Injection

In 1929, the use of Thoratrast was described for visualizing the liver and spleen radiographically. The material is picked up by the reticuloendothelial system. Unfortunately, the half-life of Thorium is 1.4×10^{10} years.

There is a characteristic roentgen appearance with dense, multiple, radio-opaque nodular densities which not only visualizes the spleen and liver but the lymph nodes as well. A scan of the liver and spleen showed areas of increased radioactivity. At postmortem, a hepatoma was found.

The occurrence of hepatoma, osteogenic sarcoma, and endothelial cell sarcoma have been reported in cases which received Thoratrast for diagnostic procedures.



Figure 4

Thoratrast outlining liver, spleen and nodes

Twisted Dermoid Cyst of the Ovary—a Case Report and Discussion

Louis P. River, III, Captain, U.S.A.F., M.C.

Torsion of the pedicle of an ovarian cyst often produces acute, severe and unremitting abdominal pain which may be difficult or impossible to differentiate from the more common medical and surgical causes of acute abdominal pain. Among ovarian cysts which can be involved in this accident, teratomatous ones are seen with the least frequeny. The following case is reported because of interesting features in the diagnosis and pathology.

Case Report

Mrs. G., 29-year old wife of an Air Force Captain, was first seen on January 30, 1962, with a complaint of gradual onset of steady, severe, sharp, right lower quadrant abdominal pain during the preceding 18 hours. The pain radiated into the right flank and ambulation caused extension of pain down the posterior aspect of the right thigh. Anorexia and nausea were present from the onset of the pain but there was no vomiting. The patient stated that she had urinary frequency and urgency associated with a persistent urge to defecate beginning shortly after the onset of the pain. She was gravida II, para II, with normal menstrual periods starting five weeks after the birth of her last baby in December 1960. Her last menstrual period ended January 12, 1962. Past medical history was negative except for moderately severe low backache during the two weeks preceding onset of present illness.

Physical examination revealed generalized abdominal tenderness on palpation—maximum in the right lower quadrant—with extension into the right flank. There was moderate rebound tenderness in this area but no involuntary rigidity. No masses could be detected in the abdomen, and bowel sounds were present but hypoactive in character. Pelvic examination revealed tenderness on manipulation of the cervix with severe pain on palpation of the posterior cul-de-sac. Obesity and severe pain prevented complete bimanual examination but the uterus was felt to be of normal size. Her temperature was 100 degrees rectally, pulse 88, and blood pressure 118/68.

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March Air Force Base Hospital, California

Laboratory data included a white blood cell count of 12,800, with 72 neutrophils, eight bands, 16 lymphocytes, and four eosinophils. Hematocrit was 42 per cent. A catheterized urine contained six-eight RBC/hpf. Scout films of the abdomen showed small bowel air indicative of early paralytic ileus. An intravenous pyelogram was negative.

Approximately six hours after admission, an exploratory laparotomy was done. This revealed a 14-centimeter, globular, cystic tumor of the right ovary with torsion of its pedicle. Several suture ligatures were applied to the pedicle without detorsion. The pedicle was transected and the tumor was removed. Incision of the cyst showed it to be filled with oily liquid, hair, and sebaceous debris. The remaining pelvic organs and those of the general abdominal cavity were negative for pathology on inspection and palpation. Appendectomy was performed incidental to the other surgery. Recovery was uneventful and the patient was discharged from the hospital on the eighth postoperative day.

Discussion

Neoplastic cysts of the ovary account for approximately 70 per cent of all ovarian neoplasms. Serous cystadenoma comprise about 30 per cent, pseudomucinous cystadenoma about 25 per cent, and cystic teratoma about 18 per cent.[1] These three cystic tumors, with the addition of fibroma (which accounts for about 20 per cent), make up over 90 per cent of all ovarian neoplasms.

In each of the cystic tumors the most common complication is torsion of the pedicle with production of abdominal and pelvic pain. This pelvic pain may either be low grade and recurrent or it may, as in the present case, be severe and unremitting. Weight and mobility of the cyst, trauma from sudden jolts, peristaltic movements of the intestine, and enlargement of the uterus during pregnancy have all been proposed as contributing factors. The torsion may be partial, and correct itself spontaneously or there may be several complete rotations resulting in rapid gangrene of the cyst. In Meigs'[9]

series of 60 cystic teratomas of the ovary, 21.6 per cent presented with abdominal pain produced by torsion of the pedicle as the first symptom. The percentage incidence of torsion producing acute abdominal pain as the initial symptom is somewhat less in both the serous and pseudomucinous type cysts. Occasionally, if there have been previous omental adhesions, spontaneous amputation may occur following torsion to form so-called "parasitic tumors" (about 70 per cent of these are cystic teratomas). In addition to torsion, complications include rupture of the cyst, suppuration, and malignancy. There is a high rate of malignancy in the serous type, and rupture is common during both growth and attempted surgical removal in the pseudomucinous type. Malignancy and rupture are uncommon in cystic teratomas.

Teratomas of the ovary may be divided into two types—cystic and solid. One definition applying to both is a "tumor consisting of various tissues not normally found at that site." The term "dermoid" is often used rather than cystic teratoma. However, the common occurrence of all three germinal layers in this tumor makes cystic teratoma a more accurate identification.

The tissues present in both types may have the character of mature or immature normal tissues. Usually, however, they are mature and well differentiated. They are mixed together in proportions and architectural relationships unlike the normal. Most of these tumors arise in either the male or female gonads, but they can originate in many other organs.

The solid teratoma is rare in ovarian tissue. When found, it is usually highly malignant. The cystic teratoma is 200 times more frequent, and it has a malignancy rate of less than one per cent. Characteristically, the solid teratoma has all three germinal layers, with the fetal elements being of undifferentiated type.

The Cystic Teratoma

The cystic teratoma has ectodermal structures present in all instances. Mesodermal structures are present in 93 per cent of cystic teratomas, and entodermal tissues are found in 71 per cent. Blackwell et al,[3] reporting on 225 consecutive cystic teratomas removed surgically at the Mayo Clinic, felt that complete serial sections of the dermoid tubercle or nipple area of the cystic teratoma would bring the mesodermal and entodermal representation close to 100 per cent.

The cystic teratoma is usually unilocular, but in about 10 per cent of cases it is multilocular. More than one cystic teratoma may occur in a single ovary. The tumor contains an oily substance which is liquid at body temperature, but usually solid at room temperature. When such a tumor perforates into the peritoneal cavity, the greasy material may establish a peritoneal reaction which ends in the formation of nodules and masses simulating metastatic carcinoma implants.

At some point in the lining of the cyst there is always a node or thumb-like projection, which is either called the nipple or the dermoid tubercle. Characteristically, the core of this nipple contains a mixture of heterotrophic tissue representing one, two, or three germinal layers. About 10 per cent of cystic teratomas contain thyroid tissue (*struma ovarii*), but these tumors are rarely responsible for producing clinical hyperthyroidism. Most commonly, these tumors are less than 16 centimeters in diameter. They may, however, grow as large as 40 centimeters. Cystic teratomas occur with equal frequency in each ovary. They are bilateral in 10 to 30 per cent of cases.

Malignancy, as was previously stated, occurs in less than one per cent of cases. These malignancies, however, cover a wide range of tumor types, including squamous cell carcinoma, sweat gland carcinoma, glioma, thyroid carcinoma, carcinoid, and malignant melanoma.

Approximately 30 per cent of cystic teratomas contain teeth. These are usually imbedded in the wall, but occasionally they are implanted in rudimentary maxillae or mandibles. Rarely are they found free in the cyst cavity. Positive preoperative x-ray diagnosis can only be made when these teeth can be identified.

Areas of calcification other than teeth commonly occur in cystic teratomas, but calcified fibroids, ureteral and vesicular calculi, phleboliths, and healed tuberculous lesions with calcification may cause a similar x-ray picture. Robins and White[12] felt that diagnosis might be made on the basis of a rounded or ovoid mass of decreased density due to the nature of the

(Continued on page 647)

The History of Neurology in Chicago

Roland P. Mackay, M.D., *Chicago*

This is the sixth installment of an informative history of neurology not only in Chicago as the title would indicate but throughout the state and the nation. In a delightful and interesting style, Dr. Mackay paints a picture of the growth of neurology as seen against the times in which it was practiced—a story of a city and specialty growing together.

Sigmund Krumholz. Born in 1872, he graduated in medicine at the Bellevue Hospital Medical College in New York in 1899. Some time thereafter he came to Chicago and his name began to appear on the programs of the Chicago Neurological Society. His papers there were mostly case reports, chiefly of encephalitis, so common then, with various complications of considerable interest—e.g., paralysis agitans, hyperpnea and herpes zoster. In 1919 he was appointed as Instructor in Neurology at the Northwestern University Medical School, and a year later as Associate. In 1921 he was made



Sigmund Krumholz
(1872-1945)

Assistant Professor at Northwestern, and Chairman of the Department of Nervous and Mental Diseases at the Cook County Postgraduate School of Medicine. He served as Associate in Nervous Diseases at the West Side Dispensary of the United Hebrew Charities, was on the staff of Cook County and Mount Sinai Hospitals and was Consultant in Neurology and Psychiatry at the Orthodox Jewish Old People's

Read before the International College of Surgeons, Chicago, Illinois, March 19, 1963. Excerpts of this article appeared in the journal of the International College of Surgeons, August, 1963 under the same title.

Professor of Neurology, Northwestern University Medical School, and Senior Attending Neurologist, Chicago Wesley Memorial Hospital.

*For much of the material here presented on the general history of Chicago, I am deeply indebted to Emmett Dedmon's *Fabulous Chicago*.[1]

Home. He was for long years a member of the Chicago Neurological Society. His death resulted from coronary thrombosis in Chicago on January 26, 1945, at the age of 73.

Dr. Krumholz was a clinician whose interests were practical and directed to his patients personally and to the scientific features of their neurological diseases. Quiet, unpretentious, content to dwell upon the clinical aspects of his specialty, he won the loyalty of his patients and the respect of his fellow practitioners. He made no pretense to the extraordinary or dramatic, but was satisfied to do his daily tasks with competence and integrity.

George Boris Hassin was perhaps the most colorful and unique personality in Chicago neurology, whose vast labor was denied much of its reward by his stubborn and contentious dogmatism. Born in poverty in Zinovievsk, Russia August 19, 1873, he earned his way through medicine at the University of Kazan by tutoring students and caring for a tabetic patient until graduation with the gold medal in 1897. Thereafter, for some strange, quixotic reason, he practiced for 3 years in the depths of Siberia, 500 miles within the arctic circle, until, unable to silence his clamoring ambition, he went to Paris in 1900 and 6 months later to Vienna to associate with Obersteiner, Marburg, v. Jauregg, Krafft-Ebing and Nothnagel. With a vision of an American El Dorado, he sailed to New York, and continued to San Francisco, where urinalysis was all he found to do. Disappointed, he turned back to Leadville, Colorado, Denver, and finally to Chicago on September 1, 1902. He kept body and soul together on the Chicago west side by general practice, asking, it is said, fifty cents for an office visit and but little more for house calls. Thus he worked alone, caring for his patients by day, peering through his microscope by night, and reading whenever the time could be found, until after 11 years, he won a place on the neurologic staff at Cook County Hospital in 1913. By 1914 he had somehow collected enough money to go to the famous Jakob's neuropathologic laboratory in Hamburg, where the crashing onset of the first world war cut short his studies and forced him back to America. He enlisted at 41 in the United States Army and worked in the Army Research Laboratory under Lewis Weed. At the end of



George Boris Hassin
(1873-1951)

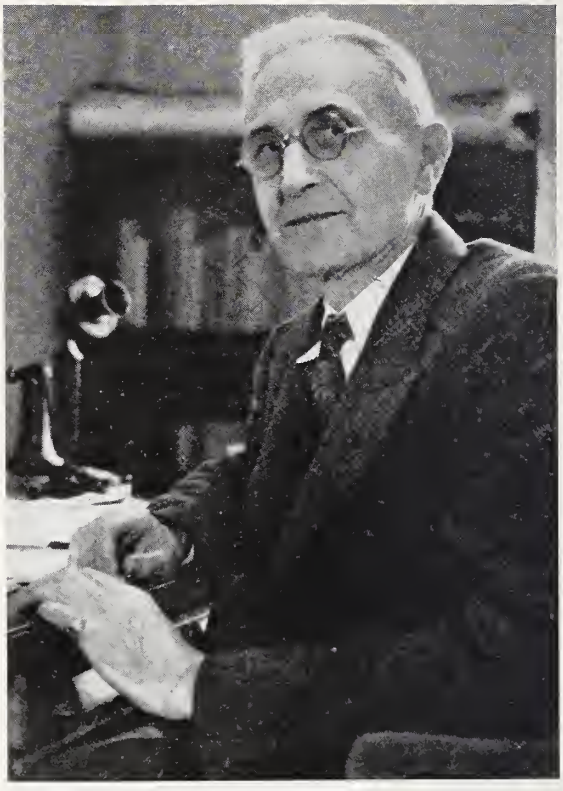
the war in 1918 he set up his own laboratory of neuropathology at the Cook County Hospital where he taught neurology and neuropathology to many, including such pupils as Percival Bailey and Roy Grinker.

Beginning in 1920, he taught at the University of Illinois, and served as histopathologist to the State Psychopathic Institute. Caustic satire became his trademark. His students listened with glee as pretenders fell beneath the pitiless hammer of his ridicule. In 1922 he was elected to the American Neurological Association and enlivened the sessions of that body with his own contributions, his trenchant and critical discussions and his biting sarcasm. His chief publication was his justly renowned *Histopathology of the Peripheral and Central Nervous System*—the first and the finest textbook of neuropathology in this country.[20] In 1941 he retired from the university but continued to work in his laboratory, daily growing more intolerant, caustic and partisan against all who disagreed with him. In 1942 he founded the Journal of Neuropathology and Experimental Neurology, thus robbing the Archives of Neurology and Psychiatry of much of its best material. He put much money into this

journal, quarreled with his co-founder, Globus of New York, tried to foree Globus out and lost, being forced out himself.

At one time a good clinician, he failed, while squinting into his microscope, to grow with elinieal seience and became an apostle of the outworn cliches. But it was his wit that described the neurosurgical credo as "no choke, no block, send 'em home." (Neurosurgery does not so readily abandon its patients now!) He never had sympathy or understanding for experimental neurology or physiology, despite the name of his journal. As a descriptive pathologist he was superb, unapproachable, although he scorned the silver and gold of the newer staining technics. Beyond description, he faltered, having an imagination unequal to pathogenesis. His death on August 15, 1951 removed from this city a vivid and pieturesque figure, who had added glory to neurology in Chicago and in America, a giant in the old style.

H. Douglas Singer, born in London in 1875 and edueated at St. Thomas' Hospital, served a residency at the National Hospital, Queen Square, where he worked with J. Hughlings Jackson and published a paper as joint author with him. He also wrote on the histology of myelitis, his early years being devoted to neurology, without any taint of the psychiatry in which he was later to achieve his chief renown. In 1904 he came to the United States to become Assistant Professor of Neurology at the Creighton Univcrsity Sehool of Medicine, Omaha, Nebraska, serving at the same time in the Nebraska State Hospital. Later he was Assistant Professor at the University of Nebraska School of Medieine, but came to Illinois as head of the Psychopathie Institute at Kankakee in 1907. In 1919 he began signal services as Alienist of the State of Illinois and Professor of Neurology and Psychiatry at the University of Illinois, where, aecording to Adolph Meyer, and as observed by many of us, he opened one "of the best managed teaching and research hospitals in the country, largely the result of his own planning and influence." Thereafter psyehiatry was his principal interest, and he contributed largely to the shaping of psychiatric theory. His basic English training remained fundamental in his point of view, in that he kept an open mind on the various fashions that sprang up in



H. Douglas Singer
(1875-1940)

psychiatry during those years. He conceived of sehizophrenia as an organie neurologie disorder with its chief seat in the dienccphalon—a view still attractive. He often served in administrative positions, was Chairman of the Committee on Mental Health, of the Section of Nervous and Mental Diseases of the American Medical Association, and was the second Editor in Chief of the Archives of Neurology and Psychiatry, where his fine sense of English diction greatly improved the style of neurologic writing.

Tall, muscular, he was yet quiet and gentle, unruffled in the heavy administrative duties that developed upon him, unostentatious but firm throughout the even eourse of his career. Upon his retirement as head of the Department of Neurology and Psychiatry at the University of Illinois, he secured the division of his department into Psychiatry on the one hand, and Neurology and Neurosurgery on the other, unfortunately placing neurology under the control of neurosurgery, a specialty noble enough, but unfitted to understand and promote the broader field of general neurology. With the best will in the world, he thus retarded the develop-

ment of neurology for decades at the University of Illinois. At his death on August 25, 1940, after a traffic accident, a sane voice was lost in the discordant counsels of psychiatry.

Theodore Thaddeus Stone was a simon-pure product of Chicago whose contributions to the knowledge and literature of neurology reflected credit on this city. Born in Chicago August 3, 1897, he earned his way with industry, thrift and tenacity to a comprehensive education, receiving from the University of Illinois the degree of B.S. in 1918 and M.D. in 1920. From Northwestern he received the M.S. degree in 1933 and the Ph.D. in neurology in 1935. As interne and resident at the Cook County Hospital, and afterwards, he was a pupil of Lewis J. Pollock. From 1922-36 he was Attending Neurologist at the Michael Reese Hospital and Clinic, and he served from 1933-46 in the same capacity at the Cook County, Henrotin and Lutheran Memorial Hospitals, and occupied the chair in the Department of Neuropsychiatry at the Wesley Memorial Hospital almost to his death. At Northwestern he advanced in neurology from Clinical Assistant in 1922 to full Professor in 1948. He never troubled to study in Europe, but continued active clinical and laboratory research in neurology as long as he lived, producing over 50 papers, almost exclusively neurological. Of these, 10 dealt with Huntington's chorea and represented important contributions to the clinical and pathological knowledge of that disease. Although he saw some psychiatric patients, he never succumbed to mystical nonsense. In his first appearance before the Chicago Neurological Society in February 1925 he read a paper on amyotrophic lateral sclerosis with Argyll Robertson pupils and he continued active participation in the meetings of that society, serving as its president in 1935. He was a member of all the major neurological societies in this country and attended three International Neurological Congresses, presenting papers at two of them.

Dr. Stone was short of stature, somewhat stocky in build, a kindly man of good humor. His teacher Pollock lavishly praised him as industrious, studious and a completely honest scientist, gifted with buoyancy, unique energy and prodigal generosity. He died on his farm near Woodstock, Illinois, on March 5, 1952.

Harry Arthur Paskind pursued a career precisely contemporary with that of T. T. Stone.



Theodore Thaddeus Stone
(1897-1952)



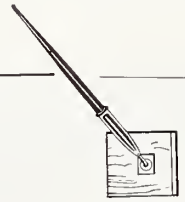
Harry Arthur Paskind
(1896-1942)

Born April 15, 1896 he was Stone's classmate at the University of Illinois and they received the B.S. and M.D. degrees together in 1918 and 1920, and were companion internes and residents at Cook County Hospital 1920-2. Also, like Stone, he took the M.S. (1931) and Ph.D. (1934) degrees at Northwestern University. From 1933-7 he served on the staffs of the Peoria, Elgin and Chicago State Hospitals. For the next 2 years (1927-9) he was assistant to Dr. Hugh T. Patrick and later, after Patrick's death, reported clinical studies based on Patrick's meticulous office records—a procedure also followed by Paskind's other teacher, Lewis J. Pollock.

Paskind rose in academic status at Northwestern University from Instructor in 1927 to Associate Professor of Neurology from 1938 until his death. He was Attending Physician in Neurology and Psychiatry at Michael Reese and Evanston Hospitals, Attending Psychiatrist to the Behavior Clinic of the Criminal Court of Cook County and enjoyed an active practice of neuropsychiatry. He was a member of the Chicago Neurological Society and its president in 1940-1, and he belonged to most of the national neurological societies in the country. Both psychiatry and neurology were of interest to Paskind. Of the first 31 of his contributions to the literature in these two fields, 10 were psychiatric, 5 on the manic-depressive psychosis. For 5 years (1934-8) he was psychiatric editor of the Year Book of Neurology, Psychiatry and Endocrinology.

One most confess that Paskind was a much less colorful personality than the companion of his school days, Theodore Stone. He was tall in stature, quiet in demeanor, perhaps pedestrian in thought, but a meticulous worker. He had a streak of stubbornness in him, which served him well. But that he was not without humor was demonstrated, for example when, on November 26, 1940, as President of the Chicago Neurological Society, he introduced the guest speaker Dr. Tracy J. Putnam of New York with the remark: "When a New Yorker crosses the Hudson, it's an incident; when he crosses the Alleghenies, it's an accident; if he gets as far as Chicago, it's a precedent!"

His premature death came before his forty-sixth birthday, of coronary thrombosis, on March 24, 1942. *(To be concluded)*



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The first page should list the title, the name of the author (or authors), degrees, and any institutional or other credits. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered, and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top, and place the author's name on the back of each illustration.

Address manuscripts to T. R. Van Dellen, M.D., Editor, Illinois Medical Journal, 360 N. Michigan Ave., Chicago 1, Illinois.

(Continued from page 635)
contents, encircled by a well-defined ring of increased density produced by the capsule of the cyst. The area of decreased density is banded or mottled, caused by hair mixed with sebaceous material.

Although the majority of cystic teratomas occur between puberty and 30 years of age, some have been reported from two months to 80 years of age. Gross[7] states that about 50 per cent of the ovarian neoplasms found in children are cystic teratomas. In Radman's[11] series of 27 ovarian tumors in children, 14 were cystic teratomas, and 20 of the 27 had torsion of the pedicle with abdominal pain as the presenting complaint.

Since these cysts are almost always benign, their removal with preservation of ovarian function in the involved ovary is possible in some cases. Levi[8] makes a plea for conservative treatment in young patients. He reports a case of bilateral cystic teratoma which was removed with the preservation of a very small portion of one ovary. There was recurrence of the tumor in the residual ovarian tissue which necessitated its removal 11 years later. Nevertheless, the patient had three normal children during the interim. Dockerty[6] advised needle aspiration of the other ovary, even though grossly normal, after removal of a cystic teratoma in hopes of "striking oil." He felt that small and medium sized tumors could be dissected free without interfering with the function of residual ovarian tissue. If the tumor is palpable or visible, simple wedge excision may be technically more feasible than aspiration followed by attempted removal.

Summary

A case of cystic teratoma of the ovary with torsion of its pedicle is presented. Factors in the pathology, diagnosis, treatment and prognosis of this condition are discussed.

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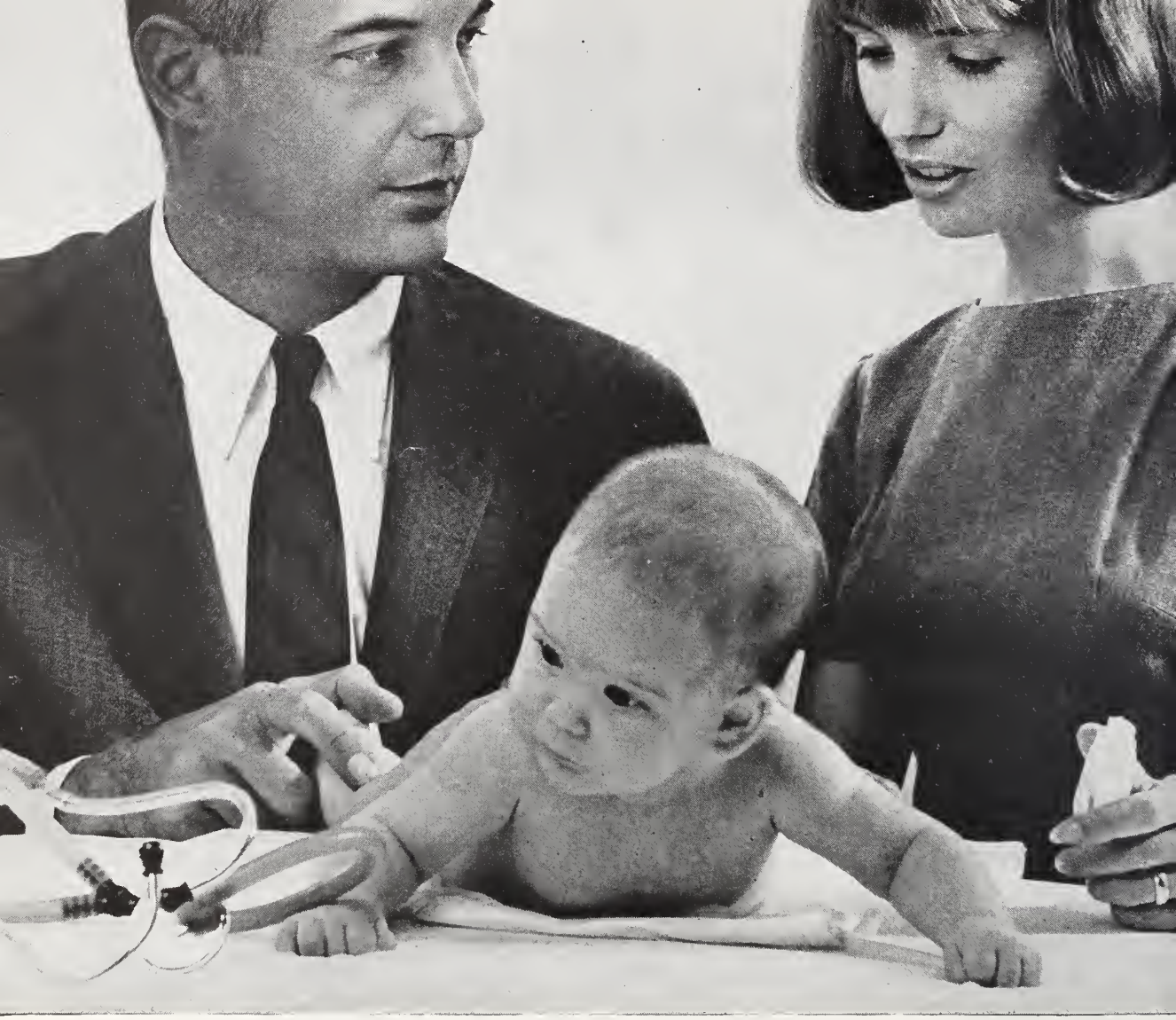
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*Donnelly, J.: A.M.A. Arch. Environmental Health 6:697, June, 1963

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The Physician's Role in Illinois' New Mental Health Code

Harold M. Visotsky, M.D.

Director, Illinois Department of Mental Health

On July 1, 1964, Illinois' new Mental Health Code will go into effect. Its provisions mirror efforts to provide early intensive treatment at the first signs of mental illness, not only at the State's existing institutions but, in the near future, right in the community at the Department's six new Zone Mental Health Centers.

The whole thrust of this new program is "crisis oriented." Its essence is early and easy access to treatment. To succeed in this goal we seek the cooperation and assistance of the medical profession, the judiciary, the legal profession, and law enforcement officials.

In addition we must enlist the understanding and support of the community at large.

Essentially, the new Illinois Mental Health Code has these four broad areas: (1) Revised hospitalization procedures, (2) protection of civil rights, (3) protection from civil and criminal liability for persons signing petitions, and (4) periodic review of all cases.

New Admission Procedures

Three new admission procedures will be introduced: (1) Informal admission, (2) admission on the certificate of one physician, and (3) admission on the certificate of two physicians.

The present Code provides for three means of hospitalizing patients suffering from mental illness.—These are voluntary admission, emergency admission, and court commitment. Court commitment tends to impede the access of patients to treatment facilities at the critical time when hospitalization is most needed. The emphasis of the new admissions procedures is to facilitate the admission of patients on a medical, rather than a legal, basis—also, at the same time, to protect the patient's civil rights.

These new hospitalization procedures are not intended to add to a physician's already heavy responsibilities or overcrowded time schedule. In fact, the effect should be just the opposite. The new procedures should enable physicians to place patients whom they believe to be in need of mental treatment into proper facilities with a minimum of formal and legal requirements. To assist physicians, we will be happy to send a copy of the new Code annotated to show the prescribed forms for each action. This

may be obtained by writing to the Department of Mental Health at 401 South Spring Street, Springfield. Certificates for signatures of one or two physicians may be obtained from the office of the Circuit Court clerk in each county after the middle of June. A brief description of the hospitalization procedures under the new Code follows:

Informal admissions: Under Article IV of the Code a person may go to a State hospital, request care and treatment without signing formal papers, or without obligating himself. If in the superintendent's judgment, he can benefit from the hospital's services, he will receive care and treatment as long as he remains. He will be free to leave at any time.

Admission on the certificate of one physician: Under Article VI, a hospital superintendent may admit and detain any person alleged to be in need of mental treatment and who is suitable for care if he does not object, upon the application of an interested person accompanied by a physician's certificate executed within 10 days before admission.

If at the end of 15 days, a patient who is hospitalized under this procedure does not agree to become a voluntary patient, a second physician's certificate may be filed at the hospital. This changes the patient's status.

Hospitalization on the certificate of two physicians: This is perhaps the most important procedure added to the new Code. Under this provision, a person in need of mental treatment can be hospitalized involuntarily upon an application for admission and certificate of two physicians. This procedure eliminates the need for court proceedings unless the patient or another interested person requests it. It allows immediate hospitalization and the beginning of treatment before any court proceedings that might later be requested or required. At the time of admission the receiving hospital must immediately confirm the need for hospitalization.

This form of admission gives peace officers an effective non-criminal means and authority to apprehend and transport the person to a hospital for treatment. In the past, generally, the only lawful means of initiating hospitalization for mental illness in such cases was the apprehension on criminal charges such as disorderly conduct.

We are making plans to insure that apprehension and transportation provide the most sympathetic and medically sound handling of patients before and during admissions procedures.

How the Patient's Civil Rights are Protected

Once the patient is hospitalized, all of his basic civil rights are protected. Within 12 hours after admission, a notice which describes in clear and simple terms the patient's rights under the Code, is required to be furnished to the patient as well as to parents, children, spouse, nearest relatives or any other persons designated by the patient. This notice and explanation of rights must be in a language known to the patient, or if the patient cannot read, it must be read to him. The notice and explanation of rights have been translated into German, Polish, Italian, Swedish, Spanish, Lithuanian, and Czech.

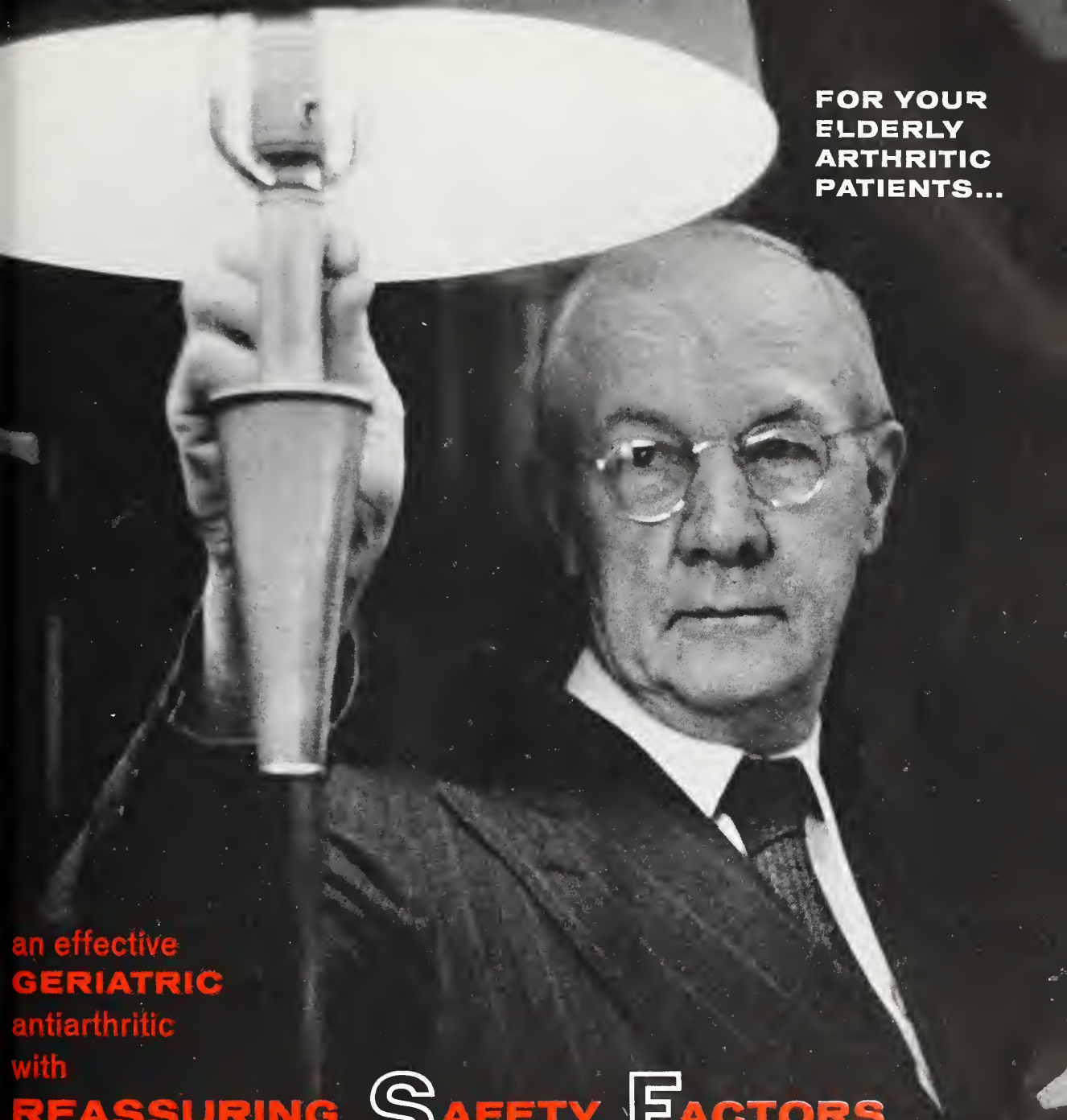
As a further protection, a magistrate or judge must consult with the patient and explain his rights under the Code within five days of admission. These rights include: (1) Fair notice to the patient and others concerned with his welfare, (2) an immediate court hearing with a jury trial if requested, (3) legal counsel, and (4) judicial review if this is deemed necessary.

Procedures for Discharge and Habeas Corpus

The procedures for discharge and habeas corpus contained in the present Code are preserved in the new Code as are the present methods of hospitalization—voluntary admission (Article V), hospitalization upon court order (Article VIII), and emergency admission (Article IX).

No matter how carefully we plan this merging of the present procedures with new hospitalization methods, it will count for nothing unless the physicians' certificates are utilized. In the past the fear of civil or criminal liability has deterred many people from signing applications or certificates, or for taking responsibility for apprehending or transporting mental patients for hospitalization. To make it perfectly clear

(Continued on page 652)



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New Mental Health Code

(Continued from page 650)

that this is a groundless fear, I quote Section 12-20 of the new Code:

"All persons acting in good faith, reasonably, and without negligence in connection with the preparation of applications, petitions, certificates or other documents or the apprehension, transportation, examination, treatment, detention, or discharge of an individual under the provisions of this Act *shall be free from all liability, civil or criminal, by reason of such acts.*"

The third major change in the new Code is the retention of a patient's civil rights. Hospitalization whether by court order, voluntary application, or admission on physicians' certificates signifies nothing other than the need for hospitalization. It does not take away any civil rights—including the right to vote or to manage property.

Finally, under the new Code, all patients, whether admitted or hospitalized by court order or by medical certification, will have clinical and court review of their cases at least every two years. This extremely significant provision is consistent with our program to provide early and intensive treatment and to see that patients are not overlooked in the far reaches of our State hospitals.

As we devote our energies and efforts toward reaching out to our communities and making treatment facilities available to persons when they need them most, we must look to the members of the medical profession to assist us so that under the new Code we can provide, in deed as well as words, early and easy access to treatment.

Looking for a Place to Practice? Placement Service Lists Openings

LAWRENCE COUNTY: St. Francisville; population 1040. Town without a physician since June 1962. (Only physician died) Nearest physicians at Vincennes, Indiana, Lawrenceville and Mt. Carmel, Illinois, 12, 17, and 21 miles. Nearest hospital at Lawrenceville, 12 miles. Nearest large city—Evansville, Indiana, 63 miles.

McHENRY: Richmond; population 900. Only physician, age 53, retiring due to physical impairment. His office available. 65 bed hospital; non-profit; now expanding. 60 miles from Chicago.

WINNEBAGO COUNTY: Pecatonica; population 1500. Two physicians; one wishes to retire after practicing here for 40 years. His building for rent. Nearest hospitals at Rockford and Freeport, 14 miles. One prescription drug store. Eight room office completely remodeled six months ago at cost of $20,000 for sale or rent. Equipment, including Picker X-ray, examining tables, etc. available if desired.

MORGAN COUNTY: Franklin; population 500. No resident physician since 1950. Nearest physicians at Waverly, 6 miles, and Jacksonville, 13 miles. 2 hospitals at Jacksonville, 102 and 90 beds. 35 miles from Springfield, population 75,000. Financial assistance could be arranged if necessary.

OGLE COUNTY: Stillman Valley; population 600. Town without a physician for several years. Nearest physician at Byron, 5 miles. 15 miles from Rockford, population 125,000. Community willing to raise funds for physician's office building. 90 miles from Chicago.

LAWRENCE COUNTY: Lawrenceville; population 6800. 8 practicing physicians in Lawrenceville ages 64, 46, 55, 46, 47, 46, 37, 63 and 75. Lawrence County Memorial Hospital located here. 70 miles from Evansville, Indiana, population 125,000.

VERMILION COUNTY: Fairmont; population, 618. No resident physician. Nearest physicians at Homer and Catlin, 7 miles. Nearest hospitals at Danville, 15 miles; population 37,814; Lake View and St. Elizabeth. Combined home and office available for a physician. Financial assistance could be arranged if desired.

WOODFORD COUNTY: Benson; population 450. No resident physician. Nearest physician 6½ miles. No physician for several years. Nearest hospitals at Pontiac, 30 miles; St. James, 51 beds, 18 bassinets, and Peoria, Methodist Hospital, 223 beds, 42 bassinets, and St. Francis Hospital, 572 beds and 92 bassinets. Population of Peoria, 111,856. Downtown office available on short notice.



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EDITORIALS

Smoking and the Alternative

The practice of medicine should not involve itself in a war against enjoyment. This is the attitude that Alvan L. Barach takes toward smoking among those of his patients who have pulmonary emphysema. He prefers that they stop smoking, but he tries to teach those who do not stop how to enjoy smoking without inhaling.

In his words: "Regardless of the adverse effects of excessive inhaling of smoke, the management of patients with chronic pulmonary disease is not necessarily confined to the heavy smoker. If the non-inhaling smoker is not significantly harmed by a habit which brings solace, the physician need not be stampeded into demanding that all smoking be stopped. Moderation in drinking was finally accepted by most physicians rather than prohibition of alcohol even in the face of the terrific cost of health and life to the heavy drinker."

Barach, Alvan L.: Physical Exercise in Breathless Subjects with Pulmonary Emphysema, Including a Discussion of Cigarette Smoking. Diseases of the Chest (Feb.) 1964.

The Thrombotic Tendency

A round table discussion on the dietary management of patients with degenerative heart disease was presented at the 29th Annual Meeting of the American College of Chest Physicians.[1] The Panelists agreed that obesity is a strain on the heart, and that a reduction in calories is indicated in persons with cardiac disease. They saw no reason to reduce serum cholesterol or the triglyceride level if these were within normal range—even in cases involving coronary atherosclerosis. On the other hand, the panelists agreed that "a low fat diet might be a reasonable thing to try, since it would be harmless, but that not everybody would agree that it would make a difference in the underlying coronary atherosclerosis."

The panel made it clear that coronary atherosclerosis was one condition and coronary thrombosis was another. The former is more likely to be associated with fat in the diet and/or cholesterol and triglycerides. The condition that triggered the actual occlusion was considered in more detail and centered mainly about subintimal hemorrhages or an increased tendency for the blood to clot.

Dr. Owren of Norway, who was in the audience, was asked to discuss what changes took place in the composition of the blood that encouraged thrombosis. He found that in all situations in which there is a thrombosis tendency, such as in the postoperative state, in thrombosing arteriosclerosis, diabetes, and hypercholesterolemia, that there was an increased activity of the antihemophilic—A factor (factor VIII), and also of the plasma factor which is lacking in von Willebrand's disease.

The actual thrombosis is initiated by platelet adhesion to collagen fibers, followed by aggregation and viscosis metamorphosis. The aggregation is caused by release of adenosine diphosphate (ADP), which is often initiated by subintimal bleeding. The von Willebrand factor is necessary in addition to ADP and calcium for platelet aggregation.

Dr. Owren found that a low fat diet with added soybean oil drastically reduced—often to normal—any increase in factor VIII and in the von Willebrand factor. He also found that hyperthrombotic changes were marked in certain types of coronary patients, particularly men between 40 and 60 years of age with disturbances of lipid metabolism. "The changes were infrequent in patients above 60 years of age with hypertension and angina pectoris of long duration without infarction." It was his opinion that physicians should attempt to separate coronary patients into two types. Those with increased thrombosis tendency would be candidates for dietary therapy.

1. Diseases of the Chest 45:1 (Jan.) 1964.



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Death Before Fifty

Bainton and Peterson published a survey in the *New England Journal of Medicine* of all deaths from coronary heart disease in patients less than 50 years of age in Seattle-King County during one year. The survey was limited to a single community and therefore eliminates the selection bias inevitable in studies based on clinical cases seen in hospital practice. In addition, hospital statistics do not include those dying at home or before reaching the hospital.

During the year, the health department was notified that 133 residents, each of whom was less than 50 years of age, died of coronary heart disease. Eleven of these were women. Only 28 of the men lived long enough to be examined by a physician during their last illness. Eight of these died just after admission to the hospital. Sixty-three per cent of the total died within an hour of the onset of the illness and 85 per cent within 24 hours. Of those dying within 24 hours, 41 per cent had experienced no previous symptoms or signs of heart trouble. The majority had an "unusually good day" prior to the attack. Only 16 per cent were reported to have emotional stress or physical exertion prior to the attack.

The authors also note that only a few of these persons were engaged in professional or managerial occupations. Ten of the men and three of the women were alcoholics. But as a group, there was little evidence to support the view that the younger coronary victim is the tense, driving, ambitious person. The 11 women bring up the question of how protective the estrogens are prior to the menopause.

Profitless Public Service Drugs

All of the ethical drug manufacturers have on their lists one or more drugs which are of use only to a limited few. Fortunately, there is no mass market for botulism antitoxin, antirabies serum, or actinomycin D, but these are on hand for use when needed. Such drugs are known to the trade as public service drugs and are provided after great cost of development at or below cost or free by the manufacturer who in many instances also pays the cost of emergency transportation. It is a great credit to the pharmaceutical industry that these products in limited demand are made available. There is more involved here than the loss-leader technic or a bid for prestige. Whatever the cynics may say, we believe that what is really involved is responsibility. The companies feel it is their duty to serve the public and the medical profession in this way. This is something to remember during the present testing period for the industry.—Editorial in *New York State Journal of Medicine*, Dec. 15, 1963.

Same Virus Family May Cause Leukemia and Mononucleosis

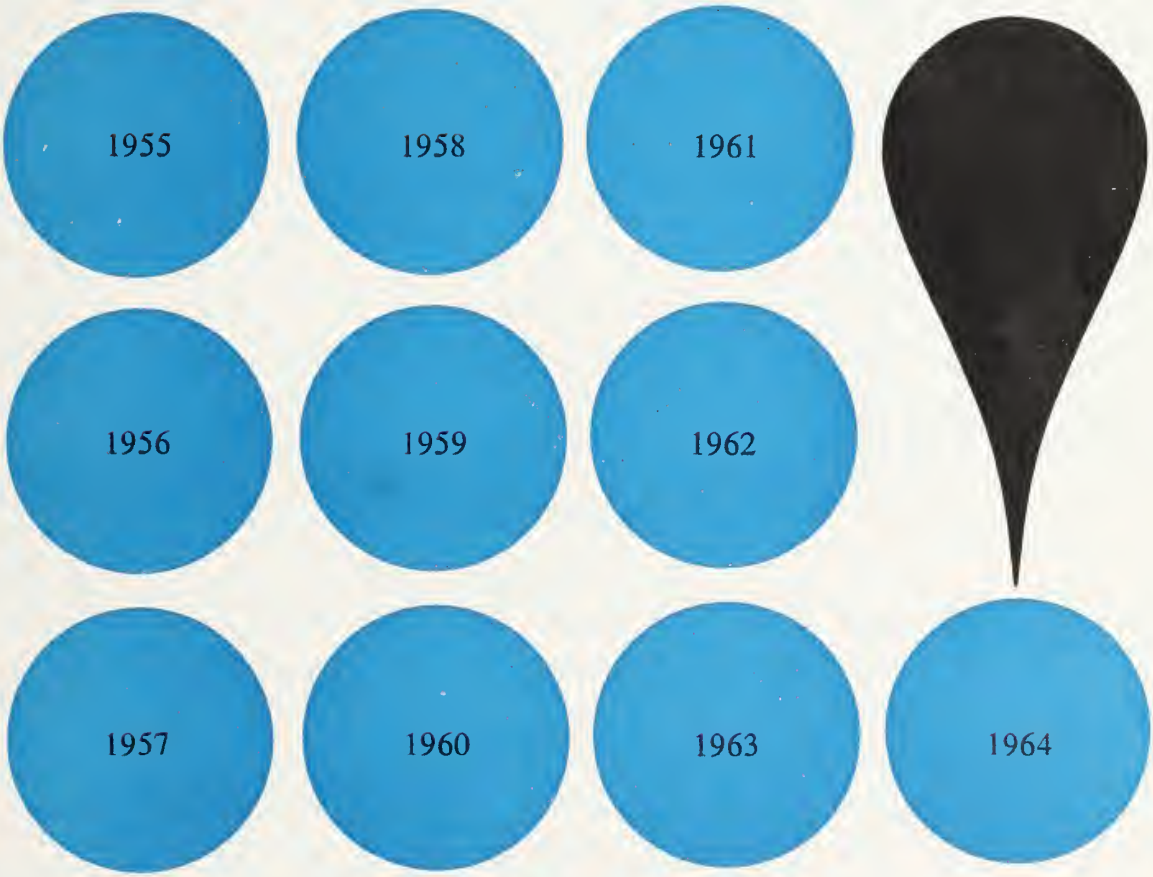
Leukemia and infectious mononucleosis may be caused by the same virus family so says Joseph L. Melnick, Ph.D., of Baylor University.

Dr. Melnick reported that large quantities of virus-like particles were found in the blood and bone-marrow cultures of more than 80 per cent of children with acute lymphatic leukemia and/or infectious mononucleosis. The particles appeared in only 10 per cent of normal children.

As seen under the electron microscope, the virus-like particles isolated from the children bore a "startling similarity" in morphology to viruses known to cause mouse and fowl leukemia. Steps to identify the myxovirus-like particles are now under way.

—*Medical Tribune*, Feb. 17, 1964.

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Surgical Pathology, 3rd Edition. Lauren V. Ackerman, M.D. in collaboration with Harvey R. Butcher, Jr., M.D. Price, $18.75; 1244 pages, 1216 illustrations. The C. V. Mosby Company, St. Louis.

Our St. Louis neighbor once again provides us with a weighty, and in some respects wonderful, tome covering the vast field of surgical pathology. This somewhat autobiographical volume culls many chestnuts from the surgical pathology laboratory of the Washington University School of Medicine. These are represented in magnificently detailed photographs of gross surgical specimens and photomicrographs.

Illustrations far overshadow text in this book. The sharpness of detail in the photographs amply justifies their large reproduction. To thumb through the profusion of pictures in this book is like walking through an arboretum where each tree is a rarity and carries its own clear descriptive label.

A number of excellent electron micrographs are added to this edition. These bring a new dimension to the study of pathology and serve to indicate some of the contributions which this discipline has made to the understanding of disease processes. This is a valuable addition.

Clinical correlation has been sacrificed to specimens in this presentation. Where clinical processes are described, they are dealt with succinctly. In some, rare entities, this is a distinct loss but in the main an excellent balance is achieved.

This book will find a place in most surgical pathology laboratories. It is a must for surgical residents and should be useful to most surgeons.

John J. Bergan, M.D.

Personnel in World War II. Available at Superintendent of Documents, Government Printing Office, Washington, D.C., 20402. Price $6.00; 548 pages; 40 illustrations; 68 tables; seven charts; 33-page comprehensive index.

Personnel in World War II discusses thoroughly the gigantic achievements accomplished in the procurement, classification, assignment, and utilization of medical personnel during the war. To briefly recapitulate, it relates the story of how enormous personnel expansion was achieved—of how requirements for the Medical Department personnel were determined—and how qualified medical personnel were secured. It discusses the difficulties encountered, and the procedures undertaken, to ensure the optimal utilization of this personnel in developing and maintaining the highest standards of professional medical care—both overseas and in the United States. Finally, it describes how the wartime Medical Department was redeployed and demobilized to the post-war peacetime level.

Since this volume is invaluable for future medical personnel planning it is recommended to members of the medical profession who may have a future military responsibility.

John Boyd Coates, Jr.
Colonel, Medical Corps, USA

Lysosomes. Edited by A. V. S. de Reuck and Margaret P. Cameron. Price, $11.50; 446 pages, with 79 illustrations. Little, Brown and Co., Boston, Mass. 1963.

This Ciba Foundation Symposium deals with certain cellular organelles. Each organelle has a labile membrane enclosing enzymes, some examples of which are acid ribonuclease, acid phosphatase, cathepsin, collagenase, and alpha glucosidase.

One of the sections deals with *Lysosomes and Pathological Cell Damage*. The reports presented include the lysosomal changes during liver injury and mammary involution, reversible activation, lysosomes as markers of fragility, the action of vitamin A on the stability of lysosomes.

In the concluding general discussion it is brought out that hydrocortisone can increase the stability of lysosomes weakened by exposure to vitamin A. Also, that hydrocortisone protects the lysosomes of fetal rat skin against cellular damage through exposure to ultraviolet rays. Considering the polymorphonuclear leucocyte as a kind of lysosome, the rare Chediak-Higashi syndrome (abnormal granulation of the polymorphonuclear leucocyte) could be included among the "lysosome diseases." Further, a suggestion is made that hyperlability or hyperactivity of lysosomes may be responsible for the "congerics of tissue lesions" in disseminated lupus erythematosus; "the excessive vulnerability to ultraviolet light of patients with this disease may be one example. It might also be suggested that the multiplicity of auto-antibodies that characterize disseminated lupus may represent a secondary phenomenon, having nothing to do with the pathogenesis of the disease itself."

Edmund Jurica, Ph.D.

PULSE
of the ILLINOIS STATE MEDICAL SOCIETY

A Service of the Public Relations Division *June, 1964*

ISMS First Medical Society "Visible" To Public

Dr. SIMS Gets Formal Intro. at Convention

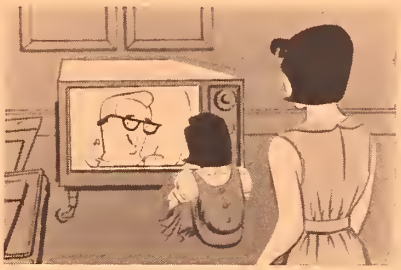
Among the dignitaries introduced to the Board of Trustees during the Annual Convention was one "Dr. SIMS."

Who is he?

Invert the first two letters of his name and you have the answer: it spells "ISMS," Dr. SIMS, new trademark of the Illinois State Medical Society, is the first such symbol ever devised for a medical association.

Beginning this summer, Dr. SIMS' face and form will accompany health messages appearing throughout the state in newspapers, on billboards, television, brochures placed in doctor's offices and posters in drugstores. In addition, his voice will be heard on a statewide series of ISMS-produced radio messages.

"For the first time the public will have a visual symbol of the medical profession," declared PR Committee Chairman Dr. Leo P. A. Sweeney. "This will associate our health messages with a physical image serving as a constant and attractive reminder for Illinois citizens to safeguard their health."



Dr. SIMS will be seen on TV . . .



in the newspapers . . .

The result of an exhaustive statewide survey to identify the typical Illinois physician, Dr. SIMS is portrayed as being between 42-48 years old; wearing glasses; and possessing an appeal that is immediately recognized by all age groups.

Dr. SIMS makes his debut in July on more than 100 outdoor billboards throughout Illinois. At the same time, "Safeguard Your Health" editorials—distributed to all 650 Illinois newspapers—will begin featuring new "Dr. SIMS" headline logos.



pamphlets . . .



coloring books . . .



and outdoor billboards

AMA Suite to "Put on Ritz" in S.F.

Transportation through San Francisco in a chaffeur-driven Rolls-Royce . . . top hats . . . foot-long cigarette holders . . . monocles . . . plus loads of expensive-looking favors . . . these are some of the eloquent artifacts to be used at the Society's Hospitality Suite during the AMA Clinical Conference in San Francisco June 21-24. Appropriately situated in Nob Hill's Fairmont Hotel, the Society's suite will carry as its theme this year "High Society." Inspiration for the theme is an exciting new adult game to be given away as a door prize.

Once inside the suite, guests will enjoy a lampooned bit of patrician splendor. Monocles and toppers will be given to the men, while ladies will receive genuine-imitation jeweled tierras plus foot-long cigarette holders (to "get away" from smoking.)

Champagne will flow freely—thanks to the generosity and cooperation of the Almaden Vineyards of San Francisco. When guests are ready to leave, they may be transported anywhere within S. F.'s city limits in a chaffeur-driven Rolls Royce—courtesy of a local auto dealer.



GRATEFUL ACKNOWLEDGEMENT is expressed by ISMS Executive Administrator Robert L. Richards, left, on receiving check for $3,250 from Merck, Sharp and Dohme Laboratories of Philadelphia to help support and strengthen ISMS Scientific Speakers' Bureau. Mr. Don Stewart, right, Field Services Manager for Merck, Sharp and Dohme, offers check.

Posthumous Award to Interprofessional Leader

The Illinois Interprofessional Council at its last meeting paid tribute to the memory of Dr. Olof Norling-Christensen when it posthumously presented its highest honor—the Distinguished Service Award—to Dr. Norling-Christensen's widow.

He died on October 31, 1963.

A past president of the Council, Dr. Norling-Christensen was also a past president of the Chicago and Illinois State Veterinary Medical Associations and was an executive board member of the American Veterinary Medical Association.

Mrs. Norling-Christensen accepted the embossed plaque and resolution before an assembly of Council members on May 26 at the Swedish Club of Chicago.

Pulse Goes on Vacation in July and August . . .



. . . but we'll be back in September—better'n ever!

Student Loan Committee Recommends 10 Men to U. of I. Medical School

The Rural Health and Student Loan Fund of the Illinois State Medical Society and Illinois Agricultural Association recently recommended 10 young college students from Illinois to begin their medical school training at the University of Illinois next September.

The men are: Norman P. Johnson, Macomb; Daniel A. Nachstein, Jr., St. Charles; Francis B. Waites, Thomson; Frederick W. Cycholl, Decatur; Charles E. Brondos, Carbondale; Jack K. Perishing, Bushnell; Charles H. Dennis, Paris; John E. Weisenberger, Browns; Thomas J. Zimmerman, Lincoln; and Robert B. Bridges, Carbondale.

Five of the men were also granted loans of $5,000 each.

The joint ISMS-IAA program—designed to help men become physicians in small towns where a shortage of doctors exists—has made it possible for more than 100 men to receive their medical degrees or to begin their practice since its inception in 1948. To date, a total of $172,500 has been contributed by both organizations on a 50-50 basis.

ISMS representatives of the committee are Drs. Jack Gibbs, Riverside, Chairman; Jacob E. Reisch, Springfield; and Thomas Bunting, Pittsfield.

Victim's Blood Used in Accident Study

A plan to take blood samples from drivers and pedestrians killed in traffic accidents was announced at the convention by Dr. Julius M. Kowalski, Public Safety Committee chairman.

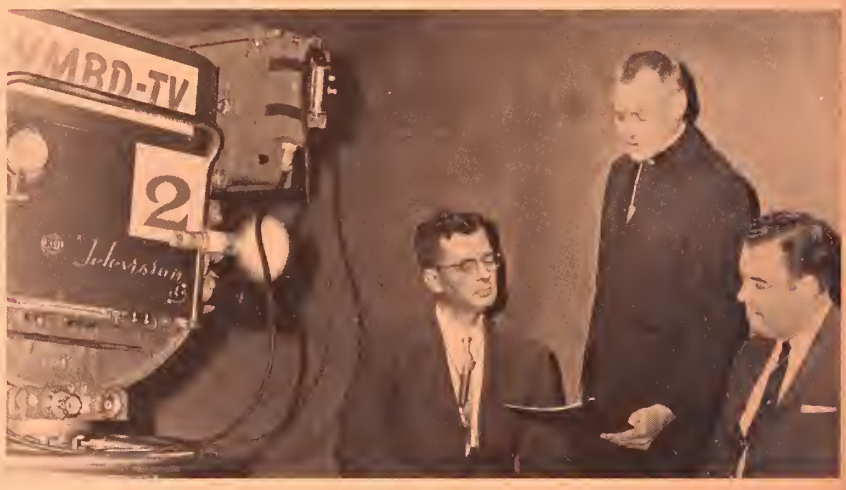
The research project—aimed at determining the correlation of "drinking" to the 2,000 vehicular fatalities which occur yearly in Illinois—will be conducted jointly by the society and the State Department of Public Health.

First of its kind, the research program will get underway by early fall and will be conducted for a total period of one year.

When a fatality occurs, an attending physician or coroner will be called in by the sheriff's deputies or policemen responding to the accident. The specimens may also be drawn by a pathologist, qualified hospital personnel at the physician's direction or a mortician.

The blood alcohols will be analyzed by the Chicago Branch Laboratory of the State Department of Public Health. The department will also supply the blood-taking equipment, report forms and mailing containers for specimens.

Peoria-AMA Team-up



COMMON PROBLEMS of physicians and clergymen were aired for local viewers last month over Peoria station WMBD-TV. Among "stars" of the show were from left: Dr. H. Thomas Gorsuch, Peoria County Medical Society; Rev. Dr. Paul McCleave, Director of AMA Department of Medicine and Religion; and Rev. Robert Thornburg, Pastor, First Methodist Church of Peoria. Program was sponsored by Peoria Medical Society in cooperation with AMA.

Convention Coverage "Unequalled"

The "highest degree" of rapport ever achieved with the Fourth Estate gave ISMS unprecedented news coverage during the ISMS Annual Convention.

Starting Sunday, the WBBM-TV 10 o'clock news show carried an interview with Belgian guest Dr. Joseph J. Farber. On Monday, Dr. Vita Marzano, one of two lady physicians initiated into the "Fifty Year Club," appeared on the "10 O'Clock Report" over WNBQ-TV.

On Tuesday, Dr. Farber appeared on the "Larry Attebery Show" over WBBM radio in the afternoon and the "Jack Eigen Show" over WMAQ in the late evening. He was interviewed for an almost unprecedented 40 minutes on the Eigen show.

The highlight of television coverage came on Wednesday when the CBS National Network "Mike Wallace Show" interviewed outgoing president Dr. Harlan English for a full 10 minutes. The Wallace show—carried by 142 stations nationally — beamed Dr. English's message to millions of viewers for a total 1,420 minutes of broadcast time.



ISMS PRESIDENT Dr. Harlan English spends last hours in office in front of national TV cameras.

Dr. Julius M. Kowalski reported on his Public Safety Committee's blood alcohol study for traffic fatalities on WBKB's 6 o'clock news show. Stations WGN, WGN-TV, WMAQ, WNBQ, WBBM and WBBM-TV also carried news of the blood alcohol project on their midnight shows.

The total broadcast box score showed a record total of more than 24 hours of "air" time over the five-day period.

In addition, close to three dozen articles dealing with the scientific and policy-making sessions of the convention appeared in the Chicago papers alone. Other major stories were sent to every daily newspaper in Illinois, and many dozens of photo stories and features were dispatched to downstate papers.



PUBLIC SAFETY COMMITTEE Chairman Dr. Julius M. Kowalski, right, tells ABC-TV's Dan Price about new traffic accident study. The first such study ever undertaken by a medical society, it will utilize blood taken from accident victims. Dr. Kowalski's TV appearance helped set a new convention coverage record.

As a result of this unequalled coverage, a resolution to convey a message of appreciation to radio, TV and newspapers was introduced by Dr. Leo P. Sweeney, chairman of the Public Relations Committee, and unanimously passed by the House of Delegates at the close of the convention.



Exactly 150 years of medical practice are represented by Drs. Vita Marzano, left, James H. Hutton and Ninah Litvin, as they exchange congratulations on initiation into the 50-Year Club. Dr. Hutton is a past president of ISMS. Drs. Marzano and Litvin were only lady M.D.'s initiated into the exclusive ISMS club this year.

"Stan The Man" will Lead Biggest CHW in History

A $100,000 program emphasizing the president's Physical Fitness Program and featuring baseball great Stan Musial will make this year's Community Health Week the biggest in history, PR Committee Chairman Dr. Leo P. A. Sweeney announced at the Annual Convention last month.

Musial—national chairman of the Physical Fitness Council—has accepted the honorary chairmanship for CHW in Illinois this year and will be featured in newspaper ads, on radio, television, drug store pamphlet racks and more than 100 outdoor billboard advertisements, Dr. Sweeney declared.

"The beauty part of this gigantic program is that it will cost ISMS only $3,000," Dr. Sweeney asserted. This is possible, he added, through cooperation with the Illinois Pharmaceutical Association, Foster-Kleiser Outdoor Advertising Company and the Advertising Council, Inc.

Plans for "phase two" of the program—aimed at stimulating participation in the physical fitness program among school children—are currently under way with the Illinois Department of Education, he added.



Stan Musial

"These efforts not only show how government and the medical profession *can* cooperate in a beneficial undertaking," Dr. Sweeney declared, "but they may establish Illinois as a permanent national model for the president's Physical Fitness Program."

AUXILIARY NEWS

EDITOR
Mrs. Oliver Veneklasen
ASS'T EDITOR
Mrs. Theodore Proud

AMA Meeting To Feature Play, M.D.-Clergy Panel

A frank analysis of problems that are both medical and spiritual, a production of a play about Homemaker Service and a luncheon honoring leaders of women's voluntary organizations are scheduled for the 41st annual convention of the Woman's Auxiliary to the American Medical Association.

More than 2,000 physicians' wives are expected to attend the June 21-25 meeting at San Francisco's St. Francis Hotel.

Monday, June 22, representatives of 45 national women's groups will be guests of honor at a luncheon. At that time, a medicine-religion program, "When Spiritual Guidance Helps," will be presented. The Reverend Paul B. McCleave, head of the AMA Department of Medicine and Religion, will outline three episodes in which people are involved in problems that are both medical and spiritual. What can be done in each case will be discussed by a physician-clergy team. Participating will be: The Very Reverend C. Julian Bartlett; The Reverend Raymond Smith; Drs. Joseph H. Kushner, Philip H. Arnot and Samuel R. Sherman, all of San Francisco, and Rabbi Saul White, New York.

Appearing on the Tuesday, June 23 program will be Miss Eleanor McGuire, health career coordinator, National Health Council, and G. P. Ferrazzano, M.D., chief, Division of Health Mobilization, Department of Health, Education and Welfare. Dr. Ferrazzano will present the Health Mobilization Award to the Auxiliary for its outstanding civil defense program.

AMA President Edward R. Annis will be guest speaker at the Tuesday luncheon honoring Auxiliary past presidents. At this time, the Auxiliary's annual contribution to the American Medical Association Education and Research Foundation will be announced. Last year's gift was $278,000.

A post-convention conference for all Auxiliary members will be held Thursday, June 25. The 1964-65 programs and chairmen will be presented, and Dr. Ernest B. Howard, AMA assistant executive vice president, will discuss principal actions of the AMA House of Delegates.

Excerpts From Our New President's Acceptance Speech

This moment has arrived with a mixture of emotions. It is an honor to receive and a very great responsibility to accept the presidency. This will be a year of fun—a wonderful time for friendship and a time of deep dependence on each and every one of you. Whether the Woman's Auxiliary to the Illinois State Medical Society becomes static or spurts forward will rest with every one of us, from the Member-at-Large to the potential, as yet unknown, new member of one of our county auxiliaries anywhere in this State.

Mrs. Evans, our incoming National President, asks that we concentrate on "Better Health—Better World". One of our national goals this year is to double our membership. I accept Mrs. Evans' challenge as one of Illinois' aims.

It is the hope of your President that she can serve you half as well as her predecessors. Our past Presidents have left an enviable record and they are most generous in giving information and guidance when asked. This is a wonderful comfort and supplies the needed continuity of auxiliary work.

These few lines seem appropriate for us all:

Talent is God-given;
Be humble.
Fame is man-given;
Be grateful.
Conceit is self-given;
Be careful.

"Always be tolerant with a person who disagrees with you—after all, he has a right to his ridiculous opinions."

Mrs. Willard Scrivner

"Bearing the Torch" for '64



Auxiliary officers and committee chairmen who will "bear the torch" of responsibility for achievements in the coming year are from left, bottom row: Mrs. A. Watson, Vice President, Community Service; Mrs. S. Plice, Vice President, Benevolence; Mrs. W. Scrivner, President; Mrs. J. Koenig, President Elect; Mrs. J. Milroy, Treasurer; Mrs. N. DuPuy, Vice President, Program; Mrs. J. Shanks, Recording Secretary; Mrs. A. Moer, Corresponding Secretary. Middle Row: Mrs. M. Uznanski, Director; Mrs. J. Prohaska, Legislative Chairman; Mrs. O. Veneklasen, Editor; Mrs. P. Clark, Parliamentarian; Mrs. W. Shriner, Finance Chairman; Mrs. L. A. Hare, SAMA Chairman; Mrs. L. Texter, Councilor, Fifth District; Mrs. W. Knaus, Press and Publicity Chairman; Mrs. P. Houk, Safety Chairman; and Mrs. F. Encres, Public Affairs Chairman. Top row: Mrs. M. Spellberg, Convention Chairman; Mrs. H. Hoegh, Credentials and Registration; Mrs. W. Roller, AMA-ERF Chairman; Mrs. R. Graff, Councilor, Eleventh District; Mrs. A. Martinucci, Mental Health Chairman; Mrs. S. DelChicca, Vice Chairman, Archives; Mrs. A. McCann, Councilor, 10th District; and Mrs. E. W. Cannady, Vice Chairman, Hospitality.

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT

The Illinois Medical Assistants Association is seeking the help of ISMS members in raising the professional standards of the state's medical assistants.

The aims of the American Association of Medical Assistants and the Illinois chapter have been lauded by both the AMA and ISMS. All Illinois physicians are urged to encourage their medical assistants to become a part of this educational organization.

IMAA Holds Eighth Annual Meeting

The eighth annual meeting of the Illinois Medical Assistants Association was hosted by the DeKalb County Medical Assistants Association and the Kane County Medical Assistants Association. Janet Ellsworth, incumbent president, presided. The meeting was held April 24-26 as Pheasant Run, Illinois.

Officers elected were: Mrs. Corinne Berg, Sycamore, Illinois, President; Mrs. Shirley Kleinschmidt, Elgin, Illinois, President-Elect; Miss Jean Berschinski, Chicago, Illinois, First Vice President; Mrs. Peggy Sorgatz, Winfield, Illinois, Second Vice President; Miss Ruth Slater, Chicago, Illinois, Secretary; Mrs. Synobia Payne, Chicago, Illinois, Treasurer; and Miss Sue Karels, Chicago, Illinois, Accounting Officer.

Two New Chapters

Two new component chapters received charters at this meeting. These were the McHenry County Medical Assistants Association, and the Tazewell County Medical Assistants Association.

Of the 360 paid members in the Illinois Medical Assistants Association, 134 were registered at this meeting. Lecturers for the educational program included Mrs. Fran Miller, of Illinois Bell Telephone, who spoke on "Winning Friends by Telephone"; Father Donald Donahugh, Rockford, Illinois, on "The Gift of Woman"; Dr. John Newkirk, Elgin, Illinois, on "Legislative Trends"; Mr. John Neal, Chicago, Illinois, on "Legal Pitfalls for Medical Assistants"; Dr. Carl Clark, Sycamore, Illinois, and Dr. H. H. Pillinger Jr., Elgin, Illinois, on "To Tell or Not to Tell"; Rev. Paul McCleave, AMA Director of Medicine and Religion, on "The Care of the Whole Man"; and Mr. Robert Howey, Sycamore, Illinois, on "Parlimentary Procedure Can Be Fun". Dr. Harlan English, President of the Illinois Medical Society was the banquet speaker. His presentation was "Medicine's Front Ladies".

Display booths were arranged by many surgical and medical supply houses for the benefit of the attending members.

There was enough time for the members attending to mingle and exchange ideas on how to make their work run smoothly, and also to discuss various educational programs for their own component societies.

Twenty-four Clinics for Crippled Children Listed for July

Twenty-four Clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The division will count 18 general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

The July Clinics are:

July 1—Springfield Cerebral Palsy (P.M.)—Memorial Hospital
July 1—Hinsdale—Hinsdale Sanitarium
July 2—Sterling—Community General Hospital
July 2—Flora—Clay County Hospital
July 8—Champaign-Urbana—McKinley Hospital
July 8—Joliet—Silver Cross Hospital
July 9—Cairo—Public Health Building
July 9—Springfield General—St. John's Hospital
July 10—Chicago Heights Cardiac—St. James Hospital
July 14—Danville—Lake View Hospital
July 14—Quincy—St. Mary's Hospital
July 14—East St. Louis—Christian Welfare Hospital
July 14—Peoria General—Children's Hospital
July 15—Evergreen Park—Little Company of Mary Hospital
July 16—Rockford—Swedish-American Hospital
July 16—Decatur—Decatur & Macon Co. Hospital
July 16—Elmhurst Cardiac—Memorial Hospital of DuPage Co.
July 22—Springfield Cerebral Palsy (P.M.)—Memorial Hospital
July 22—Centralia—St. Mary's Hospital
July 22—Elgin—Sherman Hospital
July 23—Mt. Vernon—Masonic Temple
July 23—Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital
July 24—Chicago Heights Cardiac—St. James Hospital
July 28—Peoria General—Children's Hospital

Recent reports suggest...insulin and sulfonylureas may accelerate lipogenesis,[1-5]...serum "insulin" levels are often elevated in obese diabetics[2,3,6]...DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.[1,3,7-9]

most effective in the obese diabetic

DBI® ⊘ **tablets 25 mg.**

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In the obese diabetic (ketoacidosis-resistant), DBI (phenformin HCl) with a proper diet: **A.** acts to reduce high blood sugar without increasing fat synthesis or weight gain. **B.** does not increase already elevated endogenous insulin levels; may, indeed, act to restore more normal levels. **C.** favors reduction of weight.

In the ketoacidosis-resistant obese diabetic not amenable to diet alone, hypoglycemic DBI (phenformin HCl) appears to help avoid weight gain or reduce adiposity, factors which otherwise tend to make blood sugar control more difficult and to increase the likelihood of complications. However, in the ketoacidosis-prone diabetic, insulin is still the essential hypoglycemic agent.

Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). Consult product brochure for full information.

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U. S. VITAMIN & PHARMACEUTICAL CORPORATION 800 SECOND AVENUE NEW YORK, N.Y. 10017

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies. local chapters of the National Foundation and other interested groups. In all cases, the work of the division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Film on Narcotic Addiction Available

The State of Illinois, Division of Narcotic Control, has available an interesting color sound film on Narcotic Addiction available to County Medical Society meetings. The film runs approximately 45 minutes. The Division will furnish this film and a speaker for a question and answer period pertaining to the Narcotic Drug Laws and also the Dangerous Drug Rules and Regulations, if so desired. Bookings should be made at least two months in advance by writing Joseph J. Healy, Superintendent, Division of Narcotic Control, State of Illinois, 623 East Adams St., Springfield, Illinois.

Dr. Cannady Elected as Governor of American College of Surgeons

Edward W. Cannady, M.D., newly-elected Speaker of the ISMS House of Delegates, has been selected for still another distinguished office. At the April meeting of the American College of Physicians, Dr. Cannady was elected to the post of Governor of that organization for downstate Illinois.



Twin Computers Work Tough Schedules For Medical Researchers

Scientists of the world's largest medical research organization are getting round-the-clock backup from two giant electronic computers in an all-out attack on many of the physical and mental ills of mankind. The power of twin Honeywell 800 electronic computers installed at the National Institutes of Health (NIH), Bethesda, Md., is being applied in massive daily "doses" to such medical mysteries as cancer, heart disease, arthritis and mental disorders.

"The increasing importance of computers to biomedical research has made itself felt at NIH with an explosive increase in demands for use of the Honeywell 800's," said Henry J. Juenemann, acting chief, Computation and Data Processing Branch of the NIH Division of Research Services.

Computer Usage at NIH

Computer usage at NIH has more than doubled since the fall of 1961. The first H-800 was installed in December, 1961; the second in March, 1963. Since installation both H-800's have been averaging 19 to 20 hours of work each day. In May, 1963, productive machine time reached an all-time high of 726.75 hours in one month—equivalent to 90 eight-hour shifts, or 30.3 hours a day during each of May's 24 working days.

"In any given month," Juenemann said, "about 150 out of NIH's more than 1,400 research projects involve electronic computation. Jobs range from simple calculation assignments requiring no more than a few minutes per month to lengthy epidemiological studies demanding more than 600 hours a year."

During daylight hours one H-800 works on compiling, assembling and testing new programs. Its hardware includes a central processor with 16,384 words of memory, eight magnetic tape drives, a high-speed printer and a high-speed card reader.

The second system—consisting of a central processor with 16,389 words of memory, nine magnetic tape drives, a high-speed printer and a high-speed card reader—works on small urgent production runs.

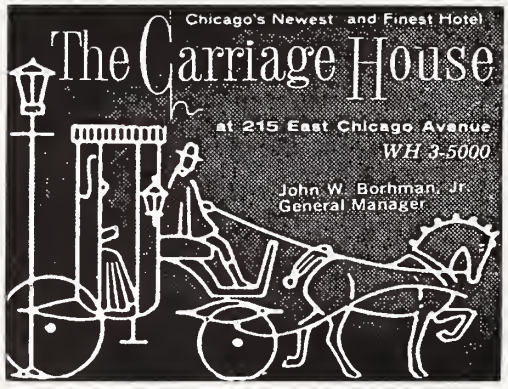
Both computers are used fully for productive computation during the night.

NIH formally established its first central computing facility in 1954. Since then it has progressed from a small punched card system to the major installation of the two H-800's. Its staff has grown six-fold to about 160 people.

How Computation and Data Processing Operates

The Computation and Data Processing Branch breaks down into two primary operating groups: (1) An analysis and programming section, and (2) an operations section.

Personnel performing analysis and programming functions are mathematician-programmers and project planners who work with the various research "customers" in the Institutes. They help the researchers formulate his experiment in terms of data processing requirements, and they also provide the mathematical



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analysis and computer programs necessary to successful accomplishment of specific jobs.

In the operations section, personnel convert input data, operate the computers and produce the final output. The section is responsible for such continuing data processing assignments as producing NIH's 11,000-man payroll and about 150 scientific jobs. Institute researchers able to handle their own programming also make use of operations section facilities.

New Drug for Hyperkalemia Treatment

SK&F Special Resin No. 648, a public service drug used in the treatment of hyperkalemia, is now available to physicians as a regular Smith Kline & French Laboratories product.

Special Resin No. 648 has been supplied free of charge as an investigational drug since 1951 and SK&F will continue to supply it without charge. A New Drug Application for the resin was filed with the federal Food and Drug Administration in May 1963.

Because of the rare incidence of hyperkalemia, Smith Kline & French had never applied for marketing clearance for the resin prior to revision of drug testing regulations by the F.D.A. in 1962.

Special Resin No. 648 is indicated for the control of hyperkalemia arising from severe renal insufficiency associated with oliguria or anuria.

The resin is supplied in one-pound bottles, and emergency supplies may be obtained directly from Smith Kline & French representatives or by telephoning SK&F in Philadelphia (Area Code 215, LOcust 4-2400). An emergency supply can be made available in less than 24 hours.

Botanists Describe Natural Smog

Botanists Reinhold Rasmussen and F. W. Went told a meeting of the National Academy of Sciences that trees and other plants produce billions of tons of "natural smog" every year. The two Washington University (St. Louis) botanists explained that the bluish haze from trees and other plants give the Blue Ridge and Smoky mountains their characteristic bluish haze. They suggested that *possible* beneficial—as well as harmful—effects of smog on man should be studied.

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Medicine, Pharmacy Warn Congress on Dangers in Too Stringent Drug Testing Regulations

Washington, D. C.—The American Medical Association and the American Pharmaceutical Association have warned Congress that too stringent regulations for clinical testing could result in valuable new drugs not being approved.

The two associations testified before a House Government Operations subcommittee, headed by Rep. L. H. Fountain (D.,N.C.) during its study of drug safety requirements from both government and industry aspects.

In another development, a federal district court held that regulations of the FDA requiring repetition of the generic names of prescription drugs in labeling and advertising each time brand names are mentioned are not valid.

After a Silver Spring, Md., physician pleaded "no contest" to five counts of an indictment, the FDA said it would recommend that the Department of Justice take vigorous action against anyone suspected of falsifying drug research records. The Silver Spring physician had been indicted on charges of submitting false reports of clinical studies of five new drugs.

"While scientists in general have the highest integrity and the falsification of research data is the rare exception, this Agency views such falsification when it does occur as a menace to the public health," FDA Commissioner George P. Larrick said.

The AMA testified that "even the most extensive pre-marketing clinical tests cannot always be relied upon as completely predictive of human toxicity."

Dr. Hussey Cautions Against Federal Regulations

Dr. Hugh H. Hussey, director of the AMA's Division of Scientific Activities, told the subcommittee that "it is entirely possible that more lives could be lost by keeping a valuable drug off the market during extensive clinical trials than would be saved by gaining a precise knowledge of the exact type and incidence of all side effects."

"Physicians realize that no drug can be considered completely safe. There is always an element of risk, no matter how small, whenever a chemical agent is administered to a patient. That risk can be minimized by adequate animal testing and pre-marketing clinical trials; it can never be eliminated."

Cautioning against government regulations that become unnecessarily burdensome and restrictive, Dr. Hussey said the vital knowledge about drug toxicity "can be obtained only by utilizing the combined experience of the ultimate evaluators of drug safety—the well informed practicing physicians of the United States."

He pointed out that it is now known that the antibiotic chloramphenicol (Chloromycetin) can produce aplastic anemia.

"The incidence of this adverse reaction has been estimated from as much as one in 60,000 to as little as one in 225,000," he noted.

"Using the high incidence figure, it can be seen that, statistically, it would be possible to treat 60,000 patients with the drug before a single case of aplastic anemia occurred," Dr. Hussey testified. "It is impractical and unreasonable to conduct clinical tests of this magnitude."

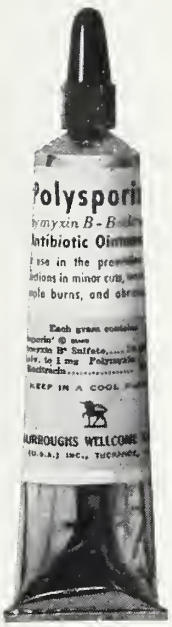
"Like animal tests, then, pre-marketing clinical trials are subject to certain limitations and can never supplant widespread clinical use as a means of assessing the ultimate hazards of a drug."

Pharmaceutical Association Statement

The American Pharmaceutical Association said that it was "concerned that the hysteria of the moment about drug safety could develop into an unwritten protocol of indecision and delay."

William S. Apple, executive director of the APA, said "the general public and individual patients must be informed that a benefit-to-risk ratio will always exist, and that every effort is being made to reduce the risk and increase the benefit."

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Fluids & Electrolytes, One Week, August 17
Pediatric Surgery, One Week, September 21
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New Illinois Diplomates in Pathology

A total of 310 pathologists have been certified this spring as Diplomates in pathology—22 from the state of Illinois—the American Board of Pathology announced.

Illinois diplomates are: Drs. James C. Pritchard, Geneva; John E. Keith, Joliet; Joseph J. Hosek, Rockford; Nathan J. Averick, Harvey; Thomas E. Moran, Oak Lawn; E. Clifford Heinmiller, Oak Park; Richard L. Kosmala, Evanston; Zenobius L. Semkiw, Elmwood Park and Earl E. Suckow, Mt. Prospect.

Chicago diplomates are: Drs. Robert W. Alexander, Tomas I. Aquino, Reuben Eisenstein, Joseph C. Erwin, Hartmann H. R. Friederici, James Y. H. Lo, Michael J. Maraganore, Regina Padleckas, Osvaldo L. Rubinstein, Won Tai Sohn, Juan J. Ugarte, Thiruchelvan Vaithianathan, and Ruth L. Wong.

Special Announcement

TO: All Poison Control Centers, Full-time City, County, and Regional Health Departments
FROM: Norman J. Rose, M.D., Chief, Bureau of Hazardous Substances and Poison Control
SUBJECT: Recommendation re discontinuance of routine esophagoscopy for hypochlorite ingestions (Clorox, and similar liquid bleaches)

A review of the literature for indications for esophagoscopy in certain instances in which hypochlorite substances, such as Clorox and similar liquid bleaches, have been ingested accidentally, indicates that discontinuance of such routine esophagoscopy has been recommended.

Accordingly, the Subcommittee on Accidental Poisoning of the Illinois Chapter of the American Academy of Pediatrics, recommends that routine esophagoscopy for hypochlorite ingestions (Clorox and similar liquid bleaches) be discontinued. This recommendation is based on the study and recommendation of the National Clearinghouse for Poison Control Centers and a report on this subject, published in the Journal of Pediatrics, August 1963, by Donald G. Pike, M.D., Joseph W. Peabody, Jr., M.D., Edgar W. Davis, M.D., and William S. Lyons, M.D., Departments of Otolaryngology and Thoracic Surgery of Children's Hospital, Washington, D.C.

Norman J. Rose, M.D., Chief,
Bureau of Hazardous Substances
and Poison Control

Pocket-Sized X-ray Unit

Scientists here have built an X-ray unit that can fit into your pocket. Furthermore, because the penetrating rays come from a radioactive source, you don't have to plug it in to make it work, according to Dr. Leonard Reiffel, vice president of the Illinois Institute of Technology Research Institute and inventor of the technique.

Sponsored by the Atomic Energy Commission, the device shows promise of supplementing standard X-ray machines in such areas as non-destructive testing problems, missile and airplane inspection, medical radiography and diagnosis. "One special advantage of the tiny unit," Dr. Reiffel pointed out, "is that its size and complete portability make it practical for on-the-spot tests of electronic equipment and aerospace components as-installed and in geometric situations where use of standard machines is impossible or impractical."

James J. Ezop, the physicist who headed the development effort on the unit, said the device has been used to detect defects in thin castings, thin welds, and potted electronic circuitry. The unit is currently under test at Michael Reese hospital as a possible tool in the diagnosis of bone diseases. It is also able to detect bone fractures and foreign bodies lodged in tissue, especially in thinner areas of the body such as the limbs.

"If common sense precautions are taken, safety of the device doesn't appear to be a problem," Dr. Ezop observed. "When it's not in operation, it can be handled for a reasonable length of time without harmful effects. When it's operating, the rays come out in the form of a column without spurious radiation. It's just a matter of staying out of the way."

The operating principle of the unit, termed a *beta-excited X-ray source,* is basically the same as for standard machines which use an electron gun to hit a target material such as tungsten or copper to produce X-rays. The resulting rays vary in quality and penetrating power according to the type of such material.

The IIT machine uses a pellet of radioactive Promethium-147 instead of an electron gun. This substance emits beta rays—electrons originating from atomic nuclei.

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—S. P. Lucia, "A History of Wine as Therapy," Lippincott, 1963.

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—"Alcohol and Civilization," McGraw-Hill, 1963.

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—Lolli, G.: Quarterly Jl. Studies on Alcohol, Sept. 1963.

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thium-147 acts as its own target. Beta rays (electrons) within the pellet hit atoms of the element, triggering the emission of the characteristic X-rays for Promethium. "The device works as a sort of camera-in-reverse," Dr. Ezop remarked. "Instead of film there is the Promethium source beaming X-rays out through an open shutter toward the object under study. X-ray sensitive film—often in the form of a fast process Polaroid developer unit—is placed immediately behind the object to get the pictures."

The device is about the size of a pack of cigarettes. Tungsten-stainless steel alloy is used for the shutter and for shielding. Other parts are of stainless steel. The shutter is controlled by a cable attachment common to many makes of cameras.

Dr. Ezop said that Promethium-147 was selected from a number of possible sources because of its good yield of relatively monoenergetic X-rays, a half life of 2.6 years, and small size. These qualities lend themselves to lightweight, miniaturized design.

For this study, a 250 curie Promethium-147 source was fabricated into a pellet 7mm in diameter by 2mm thick. The photon output spectrum of this source was relatively monoenergetic, peaking at 40 kev with a flux of 5.5 x 10^5 photons (40 kev)/sec/cm^2 at one foot from the source.

Anti-Smoking Safari

A group of physicians from Johannesburg, South Africa, are convinced that going on a safari might help confirmed smokers to break the habit. To prove their theory, the physicians have organized the first safari designed to bring back non-smokers instead of trophies. One hundred smokers have been invited to take the trip. The doctors will guide the volunteers into a setting miles away from civilization—"to places where people cannot sneak away surreptitiously to buy cigarettes."

The general idea of this theory is that if smokers are physically unable to obtain cigarettes, the temptation to smoke is diminished. The physician-guide team will also take the opportunity to study the various mental and physical problems that attend withdrawal from cigarette smoking.

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Obituaries

Franz G. Alexander*, Chicago, died March 8, aged 73. At the time of death he was residing in Los Angeles. In 1913 he was a graduate of Eotvos Lorand Tudomanyegyetem Orvostudomanyi Fakultas, Budapest, Hungary. Doctor Alexander specialized in psychiatry.

William M. Cooley*, Peoria, a graduate of Northwestern University Medical School in 1903, specialized in obstetrics and gynecology He died February 18, aged 84.

Jay D. Enright*, Bloomington, died April 6, aged 67. He was a graduate of Loyola University School of Medicine in 1925.

Brady D. Epling*, Petersburg, died April 19, aged 82. In 1908 he was a graduate of the University College of Medicine, Richmond, Virginia.

Elgar E. Evans, Streator, died January 27, aged 87. In 1900 he was a graduate of Licentiate of the Royal College of Physicians of Edinburgh.

George D. Guca, Chicago, a native of Hungary, had practiced medicine here for 50 years before retiring in 1959. He was a graduate of Eotvos Lorand Tudomanyegyetem Orvostudomanyi Fakultas, Budapest, in 1907. He died April 30, aged 88.

Daniel B. Hayden*, Chicago, died March 14, aged 85. He was a graduate of Georgetown University School of Medicine in 1904 and an emeritus member of ISMS.

Leon R. Hubrich, Chicago, died March 7, aged 67. He was a graduate of Loyola University School of Medicine in 1926.

Hugh A. McGuigan, Winnetka, a graduate of Rush Medical College in 1908, died March 1, aged 89.

Josiah J. Moore*, Chicago, died May 6, aged 77. He was a graduate of Rush Medical College in 1912. Doctor Moore was the pathologist for Little Company of Mary hospital since 1932, the founder and director of Moore Clinical laboratory, a member of Chicago's Board of Health since 1953 as well as the Municipal Tuberculosis sanitarium board and consultant to several other hospitals. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Frank A. Norris*, Jacksonville, died April 28, aged 82. In 1903 he was a graduate of Northwestern University Medical School and was later the founder and senior member of the Norris Clinic.

Raymond L. Nourie*, Kankakee, died April 18, aged 52. A graduate of Loyola University School of Medicine in 1937, Doctor Nourie specialized in obstetrics and gynecology. During World War II he received both the Bronze Cross and a Navy Citation.

N. M. Otis, Fairbury, residing in Los Angeles since 1921, died March 24, aged 91.

Franklin Porter, Worth, died April 1, aged 76.

Charles T. Roe*, River Forest, died April 29, aged 63. He was a graduate of Loyola University School of Medicine in 1932, specializing in E.E.N.T. During World War II he served as a captain in the Armed Forces. At the time of death he was on the staff of Oak Park hospital.

Meyer I. Saberman*, Chicago, died May 10, aged 55. He was a graduate of the University of Illinois College of Medicine in 1932, specializing in pediatrics. He served as an Army captain during World War II and was a staff member of Michael Reese and Edgewater hospitals. Doctor Saberman was a member of the American Academy of Pediatricians and Alpha Omega Alpha.

Charles A. Schiff*, Chicago, died April 30, aged 48, at Michael Reese hospital where he had been a staff member for 15 years. He was a graduate of Rush Medical College in 1932, specializing in surgery.

William V. Secker*, Champaign, died February 14, aged 87. In 1906 he was a graduate of Northwestern University Medical School.

William F. Weir*, Sparta, died March 1, aged 83. He was a graduate of St. Louis College of Physicians and Surgeons in 1909.

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